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VOLUME 50 **NUMBER 7**

JULY 1954

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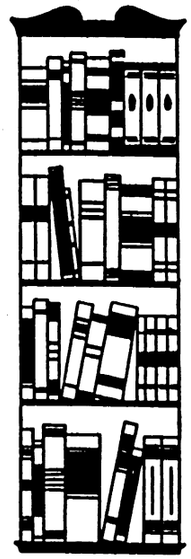

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Between Ourselves

Each year as summer vacation time rolls around we are thankful that we do not have to prepare holiday schedules for hundreds of staff members. On the other hand, with a larger staff there would probably be greater ease in shifting responsibilities from one person to another. Be that as it may, the cumulative sighs of relief from directors of nursing all over the land when all vacations are completed and everyone is safely back at work would create quite a breeze. Our own office is no exception!

This year's vacation time at *The Canadian Nurse* office will be marked by the loss of our assistant business manager, **Mrs. Kathleen Williams English.** After 16 years in the *Journal's* employ, Mrs. English is going to devote her time to problems of pediatrics, nutrition and the like. She is being succeeded this month by **Mrs. Virginia Miller,** our new assistant business manager.

* * *

Pain is a disagreeable sensation that all of us experience at one time or another. Philosophers and physicians have considered it for centuries. One view that held sway until comparatively recently was that pain, like pleasure, was simply a feeling state — an emotional reaction. The accumulated evidence now makes it clear that pain is a specific sensation not only perceived as such, but provided with a special mechanism for transmission of pain impulses. In his discussion of ***abdominal pain,*** **Dr. John Bingham,** illustrates how the person who is able to tell how he at first had epigastric distress, then nausea and vomiting, and that the pain finally settled in the right lower side of the abdomen, is much more apt to have appendicitis promptly diagnosed than the person who, weeping and excited, claims "my whole stomach hurts."

We are grateful to the *Ontario Medical Review* for giving us permission to share this useful article with you. It was published in their February, 1954, issue.

* * *

The varieties of parasites with which nurses are most familiar are those that still, unfortunately, abound in the hair and on the bodies of some of the school children and patients admitted to our hospitals. **Dr. Leo Margolis** points out that every creature is susceptible to ***ravages of some form of parasite.*** He is particularly concerned with those that are found in fish. Because of the universal use of fish as a source of food, the information he shares with us in this article has importance for every nurse. The preventive measure is so simple — ***thorough cooking.*** Nor is it only in distant foreign lands that persons are still being infected with fish parasites. We heard only recently of a child who was being treated in the pediatric department of a hospital in a Canadian city for a fish tapeworm. Eighteen feet had been recovered at that time and the head was still adherent!

* * *

We commend to the directors of nursing in our general hospitals and their staffs, the article by **Gladys Creelman** describing ***the organization of an adequately functioning public health department*** within the Victoria General Hospital in Halifax. Frequently, when a qualified public health nurse is appointed, the greater part of her time seems to be spent in curative work in the student nurses' infirmary instead of developing active preventive programs. Here is a pattern that might serve as a pilot to schools of nursing contemplating some changes.

There are some dangerous fallacies about prenatal environment, such as that the marriage of first cousins produces mentally defective children. This is certainly not confirmed by the studies of the Levinson Foundation for the Mentally Retarded, in Chicago. While an occasional case of feeblemindedness can be found in such offspring, people of unusual talent and intelligence are often born from these marriages.

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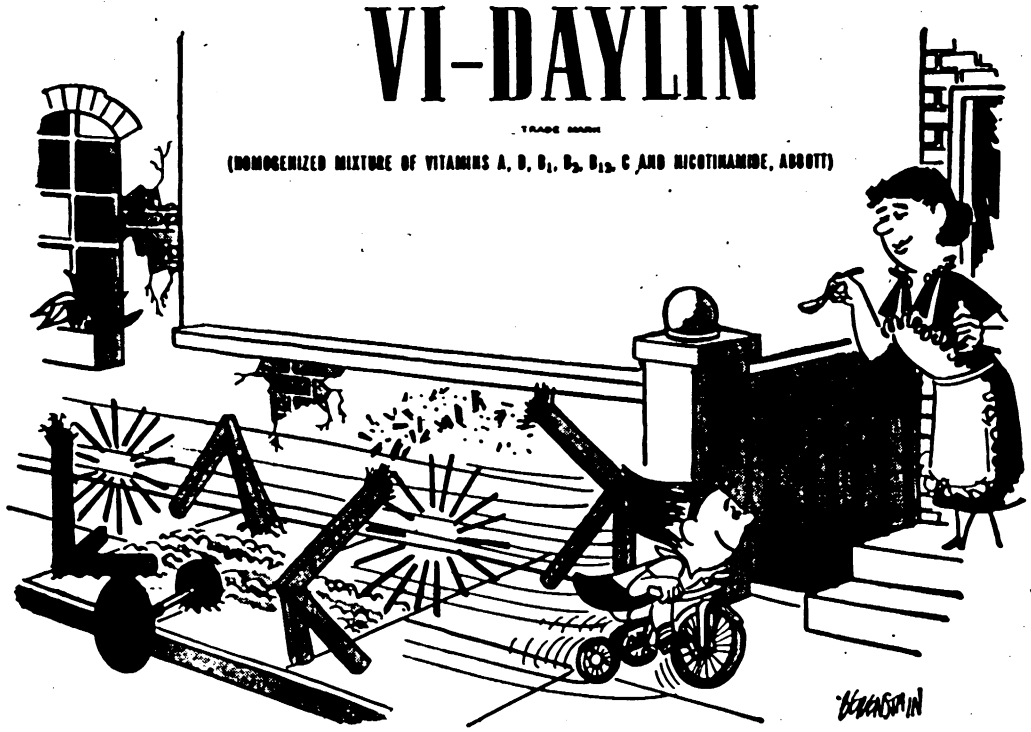

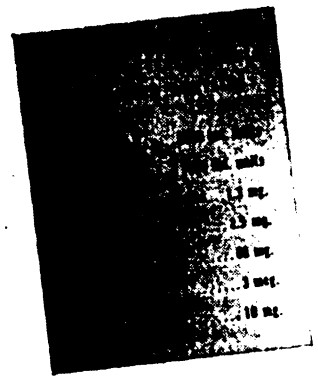

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PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 50 NUMBER 7

MONTREAL, JULY, 1954

Live Through the Summer . . .

SUMMER! SOFT, fluffy clouds in a sunny sky. Warm sand and cool, sparkling water. Picnics under a shady tree. Relaxing vacation hours when the hospital ward or the child health centre seem a million miles away. Summer!

Summer! The scream of a helpless victim who ventured too far and could not swim. The agony of a severe sunburn. The chill silence after the car did not make the curve safely. Summer!

The summer months are here and, like thousands of other Canadians, nurses are investing their cautiously guarded savings to secure their cherished vacation. One would think that, of all people in the community, nurses who see the aftermath of car accidents, sunstroke and near drownings would be the most safety conscious of citizens. Yet every summer there are nurses among the casualties. In order that they may live through the summer — and like it — let us take a look at some of the hazards and some of the essential items that will act as preventives.

Perhaps the most dangerous time of all on a vacation, especially for those with or travelling in a car, is the *driving* involved in getting there and coming back. Even though an alarm clock is an abhorrence on a holiday, rise early and travel while fresh physically. Accidents are more common when jaded nerves and tired eyes fail to give warning of impending trouble. Start and stop early. Don't let a "wreck creation" spoil the fun!

Every nurse should know how to *swim*. Even experts go into cold water gradually. Try not to swim alone or when tired, overheated, chilled, or right after a meal. If there is any trouble keep the arms and legs still. Even with cramps, one can stay afloat by keeping still. When help comes, don't grab the rescuer — or try to climb into a boat over the side. Wait until it is safe to be pulled in — over the stern.

Boating is fun if managed correctly. Point the bow into the wind if a storm should blow up. Get the weight into the middle of the boat but don't let more than one person shift position at a time. Stay with the boat if it is swamped or overturned. It is much easier for rescuers to spot a boat hull than a bobbing head.

Hiking or climbing calls for strong, comfortable shoes that grip well. Relax if you feel yourself falling. Always try

to make camp before dark. If lost, mark the trail obviously as you move about.

Heat stroke and *heat exhaustion* have very different symptoms. Long exposure in a hot sun may precipitate sunstroke while heat exhaustion may occur even when one stays in the shade. In the former, the symptoms are headache, nausea, dizziness and an overheated sensation. In heat exhaustion the face becomes pale, the pulse weak, temperature subnormal and the skin cold and clammy.

Different first aid measures are indicated in the two conditions. Sunstroke calls for the head to be raised and ice or cold cloths applied, cool drinks, and cold water splashed on the body. In heat exhaustion, keep the head low, apply warmth, drink strong tea, or water containing salt.

Insects and slamming screen doors are two of summertime's most common annoyances. No sooner are all the mosquitoes cleared out of the house than half a dozen people flock in, leave doors ajar and there is another mosquito! To lick these warm weather comfort destroyers, spray 5 per cent DDT on porches and on *both* sides of screen doors. Use 16-mesh-to-the-inch screens on doors and windows to keep out everything that flies. Hang screen doors to open *outward*. Treat mosquito bites with calamine lotion or ammonia water.

An added pest in some areas is the tick — a tiny brown insect that burrows under the skin. If holidaying in such a area, check the clothes and skin surfaces daily. Should a burrowing tick be found put the lighted end of a cigarette against its body. If the head stays in the skin, dig it out with a sterilized needle. Use iodine on the wound.

There are few varieties of poisonous *snakes* in Canada, fortunately. The areas are well known, so any nurse holidaying in these places should carry a snake kit. A fiery pain, two small punctures, discoloration or swelling are signs of a bite. Apply a tourniquet *above* the bite, loosening it every quarter of an hour for one minute. Cut a cross through each puncture and suck the wounds for half an hour. If alone, *walk* slowly for help.

Poison ivy causes intense itching and a burning pain. Wash the skin with laundry soap, rinse well, then sponge with rubbing alcohol. Have contaminated clothing dry-cleaned.

In spite of all the unpleasant possibilities sketched here, we hope every nurse will have a happy, refreshing vacation this summer.

To any observer of the political scene, the general attitude towards public life is startling. Many institutions, fearful of inviting economic or political reprisals, refuse to permit their people to take any active part. The ordinary voter, as a result of timidity, laziness, and for a variety of purely selfish reasons, is indifferent.

The basic reason, however, is not economic fear, timidity, or selfishness. It is ignorance, and the indifference of those with the background of knowledge and wisdom who are capable of giving leadership. Constitutional government, its history, and the climate and conditions which enable it to operate successfully, are neither generally known nor understood. Its strength and virtue, though little realized, lie in diversity and the distribution of responsibility and not in uniformity. We do not live in a political or economic strait jacket. We progress by trial and error. We make mistakes but those mistakes are corrected automatically without serious damage.

This country needs the leadership of individuals with moral courage founded on knowledge and understanding. Where else should it be found more readily than among university people, the men and women who have had an opportunity to learn the lessons of history and economics, to study the wisdom of those who have preceded us, to acquire breadth of viewpoint and clarity of thinking. That comes as the result of reading, thinking, and free discussion of ideas in schools and colleges — in short, of education. Out of it should emerge intelligent leadership of a moral, informed and rugged character.

— H. R. MILNER

Abdominal Pain

JOHN BINGHAM, M.D.

AN UNDERSTANDING OF THE mechanism of abdominal pain is essential for the accurate diagnosis of gastrointestinal diseases. To help us understand this problem, let us review some of the less controversial aspects of the subject. Let us follow pain from its stimulus of origin, along the nerves to the brain, and observe the characteristics of the sensation recorded there.

What are the stimuli which produce pain? The digestive organs, in the healthy state, are insensitive to most forms of painful stimuli. They can be cut or burned without pain. Because of this fact, it was believed for many years that the pain of visceral disease did not arise in the diseased organ, but in surrounding tissue supplied with somatic or spinal nerves. Then, in 1911, Sir Arthur Hurst, proved that the viscera were sensitive if the proper

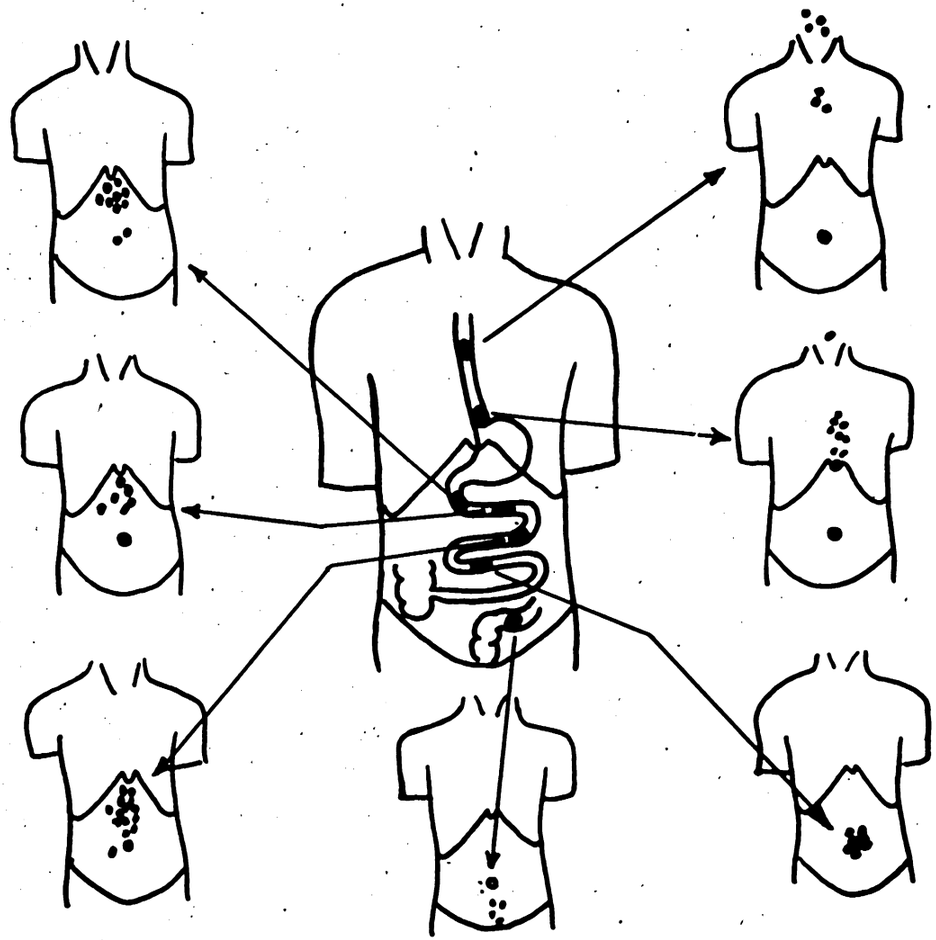

Figure 1.

The localization of pain produced by balloon distension of various parts of the esophagus, stomach and intestines.

stimulus was used. This stimulus was smooth muscle tension or stretching. Many still believe that muscle tension is the only pain-producing stimulus. This is true when the viscus is healthy. Recent evidence suggests that when the viscus is diseased other stimuli may evoke pain; pinching, pressing, chemical stimuli, or even powerful peristaltic waves produce painful sensations. [2, 3]

What is the pathway for transmission of the painful impulse? The nerve impulses, produced by the painful stimulus, pass along nerve fibres in sympathetic nerves to the spinal cord and then to the brain. Although the pain fibres travel in *sympathetic pathways, they are not sympathetic nerves.* They travel in sympathetic bundles for "convenience." The vagus nerves do not appear to carry painful stimuli from the abdominal viscera. Thus a sympathectomy may relieve abdominal pain but a vagotomy is ineffective.[4]

What sensation is felt when the impulse reaches the brain? When the pain impulse reaches the brain, the brain localizes the origin of the pain, not in the diseased organ, but to a particular area in the abdominal cavity which could be called the visceral segment. The pain is felt deep within its visceral segment. It is usually described as a sickening or gnawing, steady or crampy distress. Often the patient is unable to find words to describe the pain. The location of the visceral segments can be seen most easily from artificially produced pain.

The heavy black dots in the central figure *(Fig. 1)* represent the balloon of a Miller-Abbott tube placed in the various parts of the gastrointestinal tract. The balloon was distended until pain was produced and the site of the pain, or the visceral segment, was recorded. Each dot in the peripheral figures represents the studies in one patient.

Esophageal pain — The distension of the upper esophagus produced pain felt either in the neck or deep to the upper sternum. Pain arising in the lower esophagus was felt deep to the lower end of the sternum or in the upper epigastrium. If the pain stimulus was excessive, the pain was felt in the back.

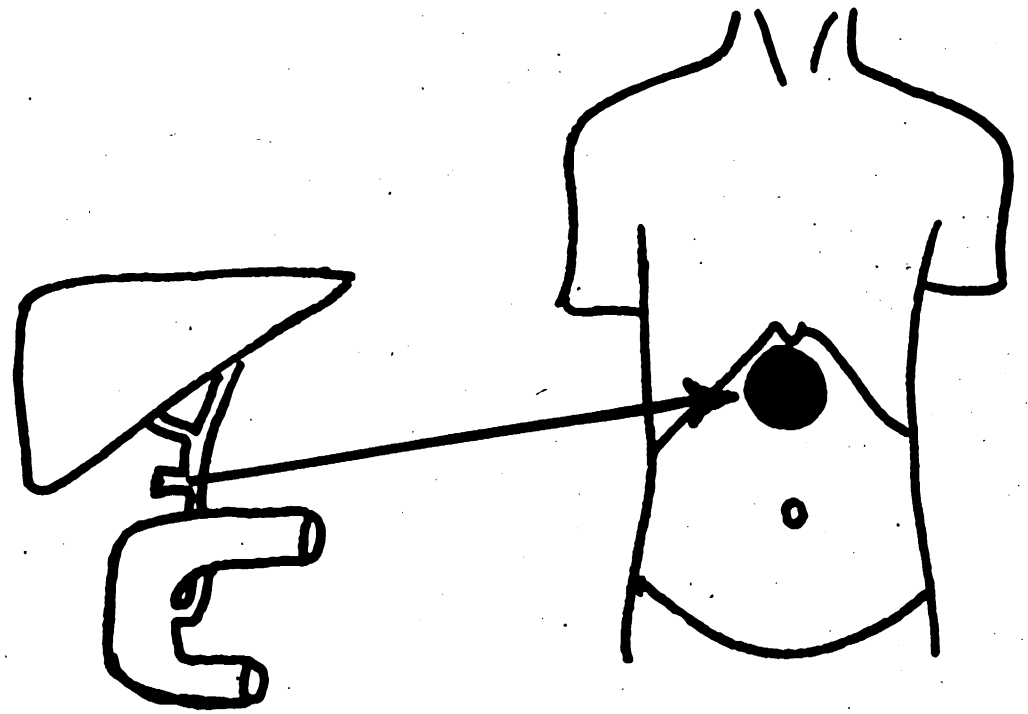

Figure 2.

The localization of pain produced by water distension of biliary passages.

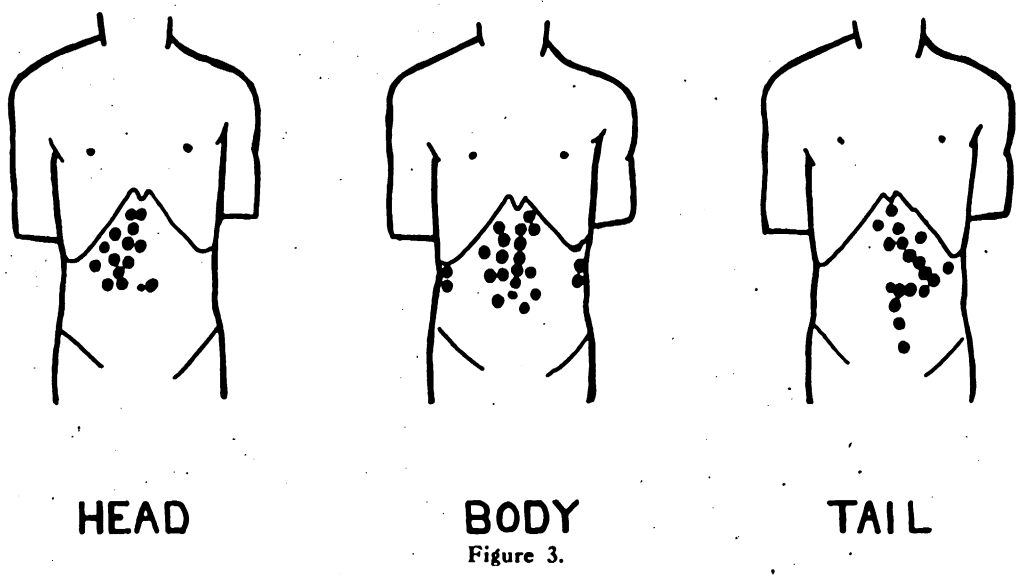

Figure 3.

The localization of pain produced by electrical stimulation of the head, body and tail of the pancreas. (After Bliss, et al.)

Gastric pain — is not shown in *Fig. 1,* but corresponded to duodenal pain in the situation in the epigastrium.

Pain from the jejunum was felt in the epigastrium whereas pain arising in the *ileum* was periumbilical.

Pain from the rectum was felt below the umbilicus.

Biliary tract pain was artificially produced by water distension, under pressure of the biliary tract *(Fig. 2).* The pain was felt in the epigastrium and was indistinguishable from duodenal pain. The author has simultaneously produced duodenal pain and biliary tract pain in the same patients at the same time and found the patients unable to differentiate one from the other.

We are indebted to the recent work of Bliss and his co-workers[5] for information on *pancreatic pain (Fig. 3).* These workers inserted electrodes into the head, body, and tail of the pancreas during surgical operations. The wires from these electrodes were brought out through the operative incision. A few days later the various parts of the pancreas were electrically stimulated and the pain produced was recorded. Pain arising in the *head of the pancreas* was felt to the right of the midline and extended from the xiphoid to slightly below the umbilicus. Pain arising from the *body* was located in the midline from the xiphoid to the umbilicus. Pain arising in the *tail of the pancreas* was felt anywhere from the xiphoid to just above the groin with the majority just to the left of the midline. Stimulation of all three produced a band-like pain radiating across the abdomen.

We may now summarize the visceral segments for pain arising in the various digestive viscera *(Table I).*

Table I.

Site Stimulated	*Visceral Segment*
Upper esophagus	Upper sternum or neck
Lower esophagus	Lower sternum or upper epigastrium
Stomach, duodenum, biliary tract, pancreas	Upper epigastrium
Upper small bowel	Lower epigastrium
Lower small bowel and appendix	Periumbilical region
Colon	Subumbilical region

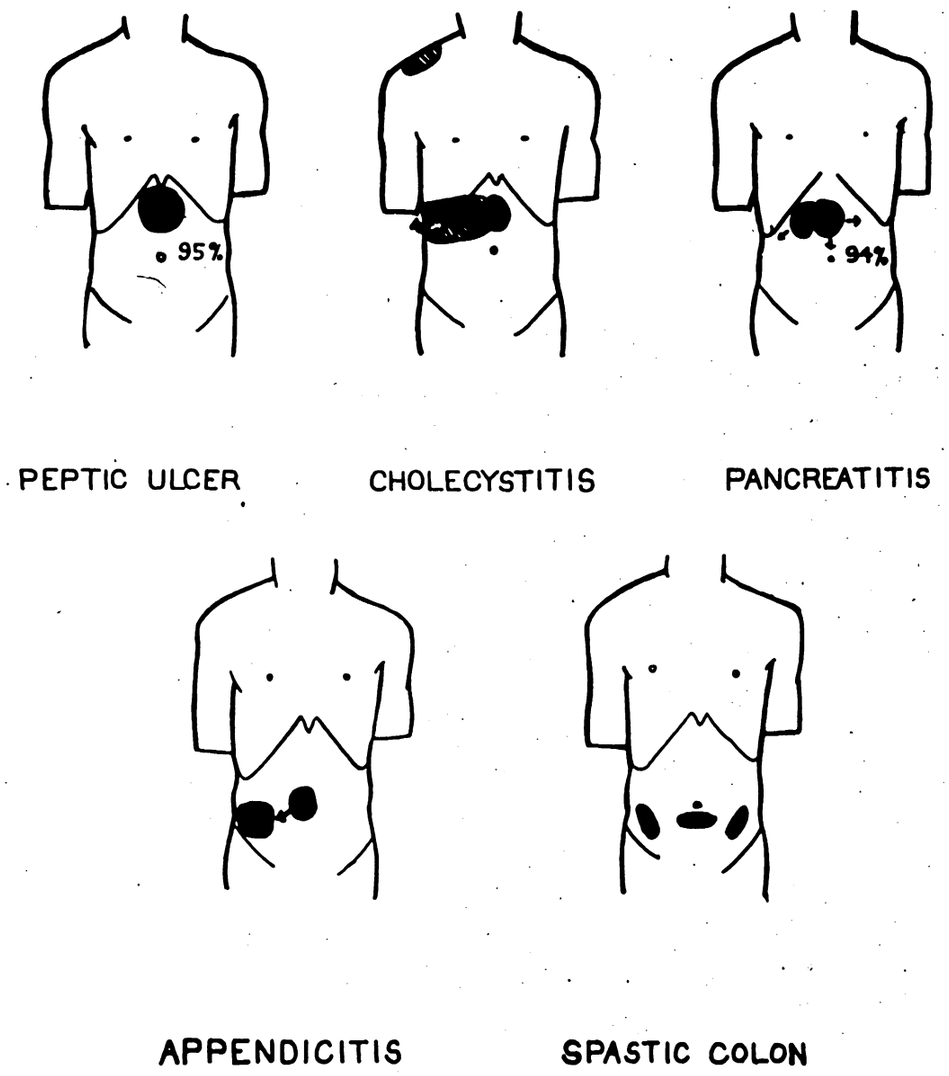

Figure 4.

The localization of pain arising from disease of the digestive organs.

With these visceral segments in mind let us turn briefly to the pain of clinical disease.

The most common location of pain of peptic ulcer, cholecystitis, and pancreatitis is shown in *Fig. 4*. As one would expect from the experiments already mentioned, the pain of all three will be similar and will be felt in the epigastrium. This, unfortunately, adds to the difficulty in the diagnosis of upper abdominal disease. Many patients with cholecystitis have pain predominantly in the right upper quadrant or even the right shoulder.

The common site of pain of appendicitis and a spastic colon is also

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shown in *Fig. 4*. The pain of appendicitis resembles the pain produced by distension of the ileum, that is, it is felt in the periumbilical region. The pain of the colon is in turn felt below the umbilicus. Here again it is noted that the pain of an appendicitis does not always occur in the periumbilical region, but is often felt in the right lower quadrant.

Now what is the explanation of the right upper quadrant, or right shoulder pain, of cholecystitis and the right lower quadrant pain of appendicitis? You can think of many other examples of variations of pain from the typical visceral locations already described. This second type of pain has been called *referred pain*. Very little is known about this pain and various theories have been advanced to explain its mechanism. None adequately accounts for all the aspects.

Referred Pain

Referred pain appears to occur in the following circumstances:

When inflammation develops — In the early stages of acute appendicitis, if appendicular colic is prominent, the pain is periumbilical. As inflammation develops, the pain moves to the right lower quadrant. Biliary colic is usually felt in the epigastrium. As inflammation develops in the biliary tract the pain moves to the right upper quadrant. This type of referred pain apparently occurs without any involvement of surroundings tissues innervated by somatic nerves.

When the disease process involves parietal structures supplied by somatic nerves — The parietal peritoneum and the roots of the mesenteries are supplied by somatic and spinal nerves. Stimulation of these tissues produces pain referred along these nerves. For example, the pain of cholecystitis may be referred to the shoulder if the diaphragm is irritated. In this case the pain is referred along the phrenic nerve.

As an accompaniment of visceral pain of extreme severity — In certain cases we can only explain referred pain as an accompaniment of visceral pain of extreme severity. The pain produced by balloon distension of the duodenum is felt in the epigastrium. If the balloon is distended further the pain becomes agonizingly severe and is felt over a wider area and in the back.

Cutaneous hyperasthesia, muscle tenderness, and muscle spasm should be sought for in all cases of abdominal pain. They frequently accompany referred pain and appear to depend on the same reflex arcs.

The difference between true visceral pain and referred pain are summarized in *Table II*.

Table II

	True Visceral Pain	Referred or Somatic Pain
Origin of Pain	Viscera	Viscera or somatic area
Type of Pain	Sickening, gnawing, boring	Sharp, burning, aching
Location	Visceral segment	Referred over somatic nerves
Muscle spasm and cutaneous hyperesthesia	Absent	Frequently present
Anesthetizing skin and muscles over painful area	No relief of pain	Frequent relief
Sympathectomy	Relieves	No relief

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Surgery of the Gallbladder and Biliary System

EMILY ELNICKI

ANATOMY

THE EXTRA-HEPATIC BILIARY TRACT of man consists of: the gallbladder, the cystic duct, the hepatic duct and the common bile duct. The gallbladder is pear-shaped, situated in the lower surface of the liver between its right and quadrate lobes. When filled it holds about 35 cc. of bile. On its free surface the gallbladder is covered by peritoneum continuous with that on the inferior surface of the liver. On its anterosuperior surface it is united to the walls of the hepatic fossa by areolar tissue. The neck of the gallbladder continues into the cystic duct. The cystic duct unites with the hepatic duct at right angles in the hepaticoduodenal ligament. The hepatic duct is formed by channels from the right and left lobes of the liver. The common duct is formed by the junction of the hepatic and cystic ducts and extends to the duodenum. It passes into the hepaticoduodenal ligament in front of the portal vein and to the right of the hepatic artery, going behind the duodenum through or along a sulcus in the head of the pancreas and into the left side of the intestine below the mediam level of the duodenum. It passes obliquely through the walls of the duodenum, joins the pancreatic duct at the ampulla of Vater, in most cases, and terminates in a papilla in the mucosal surface of the duodenum 8-10 cm. from the pylorus.

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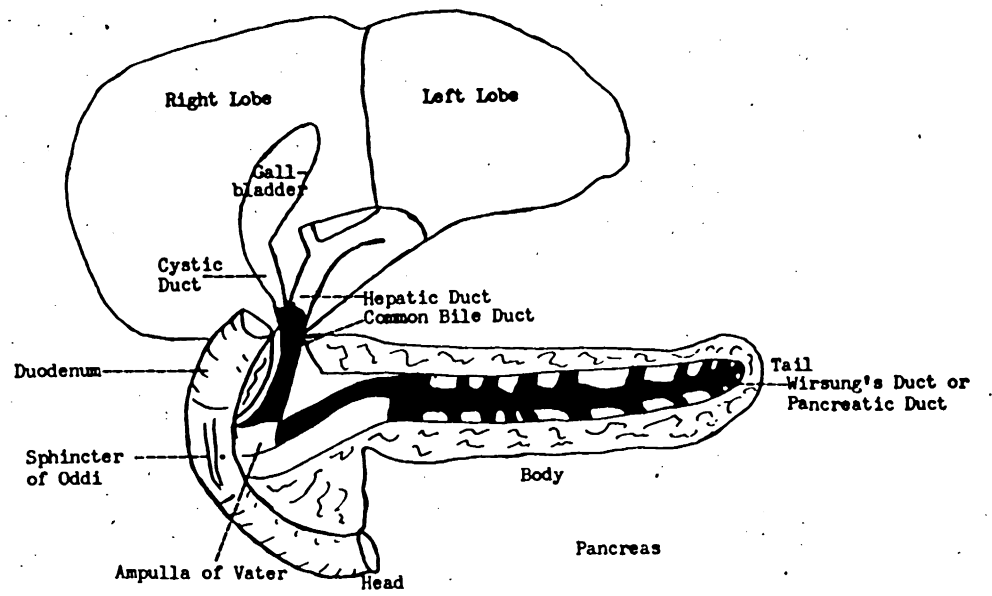
PHYSIOLOGY

The gallbladder has the general properties of: absorption, secretion and motor activity. The secretion of bile by the liver is a continuous process, but the amount secreted fluctuates. The daily output varies from 500-1,200 cc. Bile is composed of about 97 per cent water and 3 per cent solids, including 1 per cent bile salts and lesser quantities of mucin and pigments, cholesterol, lecithin and fat. The presence of bile in the intestine is necessary for the maintenance of life, it being vitally concerned with the digestion and absorption of food, particularly fats, and with the elimination of a variety of excretory products such as bile acids and cholesterol. Bile salts are effective cholagogues, stimulating the liver to increased biliary secretion.

The gallbladder is a reservoir for the bile. It is of small volume and great concentrating activity. Thus it is able to store great quantities of hepatic bile which will be discharged into the duodenum during the early stages of digestion, providing bile salts which are absorbed, and stimulating the liver to further activity. The gallbladder correlates the secretory activities of the liver with those of the gastrointestinal tract during the various phases of digestive activity. The mechanism by which it accomplishes this appears to be as follows: The gallbladder is caused to fill with bile during the fasting period by closure of the sphincter at the



Liver (under surface), gallbladder, biliary apparatus, pancreas and Wirsung's Duct.

duodenal end of the common bile duct. The bile is thus forced through the cystic duct into the gallbladder where it is concentrated, allowing the storage of all bile secreted during the interdigestive period. After ingestion of food there is a reciprocal action between this sphincter at the duodenal end of the common duct and gallbladder which permits the evacuation of the contents of the gallbladder when the bile is needed. The tone of the sphincter is decreased or abolished by the passage of gastric content into the duodenum. At the same time cholecystokinin is released from the duodenal mucosa and after absorption by the blood stimulates the gallbladder to contract and empty the contained bile into the duodenum.

PATHOLOGY

Diseases of the gallbladder and the ducts are largely concerned with the problems of infection and the formation of stones. Infections of the gallbladder may be divided into two general types — acute and chronic — and may or may not be accompanied by gallstones. Improper drainage of the gallbladder probably has something to do with the development of the infection, and the presence of stones hinders drainage. In an acute infection the gallbladder may be a real bag of pus with a thick, inflamed wall which may become gangrenous leading to perforation and peritonitis — local or general. The acute inflammation may subside, leaving a thickened damaged gallbladder which may exist over a period of years. The stones may form in the gallbladder (cholelithiasis); in the cystic duct, in the hepatic duct, or in the common duct (choledocholithiasis). They are most commonly composed of cholesterol, but some may consist chiefly of bile pigments. The presence of bacteria is said to be one of the predisposing causes of gallstones. Stones are more common in persons of middle age.

SURGICAL JAUNDICE

Normally, the bile flows freely from the liver to the intestines. In disease, the presence of jaundice means an obstruction to the flow and absorption of bile by the blood. This obstruction may be caused by stones in the common duct or by a severe inflammatory reaction sufficient to obstruct the duct. In cases of jaundice severe hemorrhage may occur from the region of the oper-

ation or from the gastrointestinal tract. In such cases the liver is damaged and, since the liver manufactures prothrombin, this vital factor in the mechanism of blood clotting is reduced. Also, since the presence of bile in the intestines is necessary for the absorption of vitamin K, its absence (as in jaundice) prevents this absorption. Vitamin K (powdered alfalfa leaf) stimulates the production of prothrombin and, in the presence of jaundice, must be administered in combination with bile salts by mouth to ensure its assimilation. Temporary improvements may be maintained by giving whole transfusion of blood.

The Patient

Mr. Bruce, a middle-aged widower of 47, has been a railway clerk for 26 years. He is short, heavy set and pale, with a rather sallow complexion. He is a quiet, retiring man who spends most of his spare time reading. He is the sole supporter of his family and therefore has many responsibilities. He lives with his father who is blind, his stepmother and one sister who is a cripple. His health practices do not seem to have been very good. He did not seem to use much discretion in his diet and worked long hours. This may have made him susceptible to infection and lengthened his illness. At first he was a very cooperative patient but, as his condition worsened, he became depressed, afraid, distrustful and even rather obnoxious at times.

Mr. Bruce had been in hospital with a tentative diagnosis of coronary occlusion and a final diagnosis of acute pancreatitis. Then, he had complained of terrific pain in his chest and upper abdomen, and nausea with vomiting of what seemed to be blood. After careful examination, E.C.G. — which was normal; various laboratory tests — showing an infection; strict bed rest; narcotics for his severe pain; oxygen therapy and general supportative nursing care, his condition improved and he was discharged. He returned to work but had persistent epigastric discomfort and bloating. He was re-admitted two months later.

Signs, symptoms and methods of diagnosis: On his admission Mr. Bruce gave a history of what he called "gallbladder attacks," including persistent indigestion after meals, severe pain in the upper right quadrant, nausea and vomiting, and a definite intolerance to fat. His temperature was 101, pulse 96, respiration 24. He was pale and perspiring profusely. His abdomen was slightly distended, rigid across the upper right quadrant on palpation. Within the next few days he complained of a more excruciating pain that radiated to the costal margin of his back and shoulders. He also had chills and fever. Jaundice became increasingly noticeable. His urine appeared very dark, his stools clay-colored. He also complained of some pruritis. Those signs and symptoms indicated biliary colic resulting from obstruction of the common bile duct.

To confirm the diagnosis of acute cholecystitis, cholelithiasis, and choledocholithiasis which these symptoms seemed to suggest, a number of tests and examinations were carried out. Several laboratory tests were made: the sedimentation rate of 60 mm. and white blood count of 11,700 showed infection. The icterus index was only six units (normal) the day of admission but rose to 29 units, then 84 units on later tests, suggesting a high concentration of bile pigment present in the blood. His prothrombin time was 60% showing some decline below the normal of 84-100 % which further suggested a bile duct obstruction. The urine appeared to be quite normal except for the presence of 3 + bile.

A gallbladder x-ray was done. This showed the gallbladder lying high and transverse apparently filled with calciferous material.

The surgical consultant who was called in advised exploration of the gallbladder and biliary system in 10 or 12 days when he hoped the acute symptoms would have subsided and it would be safe to operate. In the meantime palliative measures were carried out.

Palliative Measures

On admission Mr. Bruce was given morphine gr. ¼ with atropine gr. 1/150. The atropine in combination with the

morphine helps to overcome biliary colic by relieving the spasm of the involuntary muscle caused by the stones trying to pass through the ducts. These drugs were used q. 4 h., p.r.n. with great relief. Other analgesics and antispasmodics were also used to relieve pain as the surgeon did not want him to become addicted, by continued use, to any one drug. When he complained of pain in his right shoulder he was given a hot water bottle and a mild analgesic but with only slight relief. As his severe epigastric discomfort persisted, tincture of belladonna minims 10, q.i.d., was given. This drug has the same effect as atropine in overcoming the spasm of involuntary muscles in biliary colic. Nitroglycerin gr. 1/100 (another antispasmodic) was given sublingually a few days later, but with little effect. Demerol hydrochloride (a milder narcotic) 100 mg. was given intramuscularly. This gave relief only once and was discontinued. It was found that the best result was obtained from the atropine and morphine. It was used until his infection was sufficiently arrested and his pain much decreased.

Seconal gr. ½ was given as a sedative q.h.s., p.r.n., to ensure a good night's rest. As Mr. Bruce suffered a great deal from indigestion, Amphojel (an antacid) was given p.r.n. with some relief. Forticillin (an antibiotic), 400,000 units, was given daily until the operation to further aid in counteracting and localizing the infection.

Mr. Bruce was placed on strict bed rest for the first few days. Hot foments to the upper quadrant were applied regularly until the operation. These helped both to relieve the pain and to localize the infection. At times we had to put oil on his skin as it became very reddened and there was a danger of it blistering.

A fat-free diet high in carbohydrates, proteins, and vitamins was ordered. Fluids were forced to replace those lost by diaphoresis and also to dilute the toxins of the infection. Special stress was placed on the intake of sweetened drinks to increase the storage of glycogen in the liver to be used by the body in the post-operative period. Due to nausea Mr. Bruce could not retain fluids very well. His intake was recorded and glucose was given intravenously to maintain a high level of carbohydrate. Ascorbic acid 500 mg. and vitamin B complex 2 cc. were given intramuscularly.

The presence of jaundice, which usually indicates an increased bleeding time, made Mr. Bruce a poor operative risk. To make up for the deficiency of bile in the gastrointestinal tract, Kavitan 10 mg. I.M. was given daily to reduce the risk of post-operative hemorrhage. Caroid and bile salts tablets, 2 b.i.d., were also administered to decrease the bleeding time. This drug aids the absorption of vitamin K from the intestines.

Thus dehydration having been overcome, renal function sufficiently good to allow a safe margin for increased post-operative demands, and his acute condition having subsided sufficiently, Mr. Bruce was prepared for surgery.

Pre-operative Details

As Mr. Bruce was now feeling much improved, most of his previous medications and treatments were discontinued. The last bedpan used pre-operatively was checked and the color of the stools and urine recorded. They still showed the presence of bile so the surgeon knew that an obstruction was still present and that the operation was necessary to find its cause.

As this was not the first time he had undergone surgery, Mr. Bruce did not require much reassurance pre-operatively. He did, however, have the reasons for the pre-operative details, the proposed operation, and what he should expect post-operatively, explained to him. On the day before the operation, he was given 72 mg. of Hykinone IV. Hykinone was used instead of vitamin K for it increases prothrombin time to a satisfactory level in a much shorter time. Mr. Bruce's prothrombin time was taken six hours later and found to be 90 which was satisfactory for surgery.

That evening Mr. Bruce was locally prepared as for a laparotomy. Particular attention was paid to the gallbladder region. A large area was prepared because of the possibility that a more extensive operation than was

originally anticipated might be required.

Seconal gr. 1½ was given that evening to ensure a good night's rest. On the morning of the operation, Mr. Bruce was wakened at 6:30 a.m. as his operation was slated for 8:00 a.m. He was encouraged to void to prevent the possibility of a distended bladder, with the danger of injury during the operation, infection, and possibility of voiding while under anesthesia. At 7:00 a.m. Demerol 75 mg., with atropine gr. 1/200 I.M., was given to allay excitement and to dry secretions.

Operation

In the anesthetic room Mr. Bruce was given a general anesthetic by the inhalation method. Nitrous oxide in combination with oxygen and cyclopropane was used.

The liver showed signs of severe chronic obstruction. It was dark green, enlarged, diffusely fibrotic with rounded edges. The gallbladder was subacutely inflamed and densely adherent to the omentum. It was thickened and contained faceted stones. One large stone was palpated at the head of the pancreas near the ampulla. The common duct was surrounded by inflamed fat. The gallbladder was separated from the omentum. The duodenum was separated from the common duct and rolled downwards. In order to dissect the junction of the ducts a trocar was put into the gallbladder and a moderate quantity of white bile withdrawn. The gallbladder was opened and numerous soft faceted pigment stones were removed with a scoop. The common duct was explored with a needle and opened. An impacted stone near the ampulla was fragmented with the scoop and brought out in pieces. Eventually the ampulla was dilated one cm. A probe was passed from the gallbladder into the common duct to identify the cystic duct which was enlarged. The cystic duct was dissected free, ligated and the gallbladder removed in a retrograde manner. The gallbladder bed was satured. There was some oozing which was fairly easily controlled. The common bile duct was re-explored and three more stones were removed from the left hepatic duct. The whole duct system was re-explored with scoops but no more stones were found. Eventually all the ducts were flushed out with saline and catheter. The catheter passed easily into the duodenum. A large T-tube was left in the common duct, and a Penrose drain in Morrison's Pouch for drainage purposes; 400,000 units penicillin, 2.5 grams sulfa and 1 gram of streptomycin were left in Morrison's Pouch. The abdomen was closed in the usual manner.

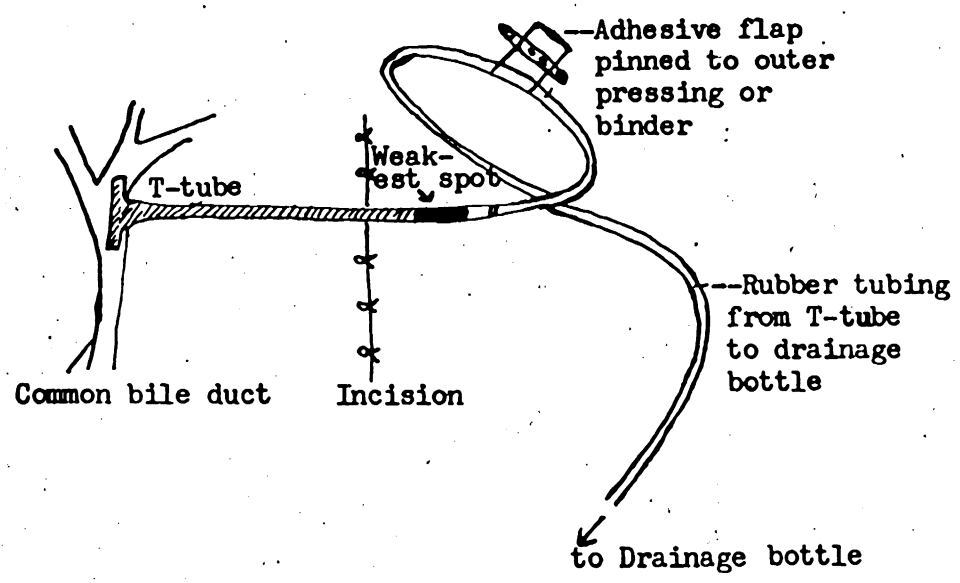
The gallbladder was microscopically examined and showed a chronic cholecystitis, cholelithiasis, and cholesterolisis.

Post-operative Period

Immediately the operation was over, Mr. Bruce was taken to the post-anesthetic recovery room. He was conscious on admission. His blood pressure, pulse, and respiration were noted every half-hour for the next few hours, since any increase in pulse or decrease in blood pressure would indicate hemorrhage or shock. His blood pressure was 120/80, pulse 78, respiration 24 on admission and remained satisfactory throughout. His bed was elevated at the foot for the first two hours, then lowered. He was given oxygen by mask to prevent shock. His dressing was checked carefully for signs of bleeding and the T-tube was attached to a sterile 1,000-cc. drainage bottle which was hooked under the bed. Care was taken that the connecting tubing was neither too long or too short and that it was fastened securely. This was very important because of the danger of the tube being dislodged or pulled out, which might have necessitated returning him to the operating room for re-insertion of the T-tube. The dressing was also checked to make sure that it was not too tight. If it were it would restrict breathing and predispose to a pulmonary complication.

Normal saline 500 cc. was given to maintain fluid balance and to compensate for that lost during the operation. Also 100 mg. of demerol I.M. was given at 11:00 a.m. for restlessness and post-operative discomfort.

As he was conscious and in fair condition he was sent to the ward. The dressing, color, pulse, respiration and



The correct way to attach a T-tube.

blood pressure were checked q. 2 h. Immediate post-operative nursing included washing his face and hands, and special care to his back, to make him more comfortable and enable him to rest. Lack of rest predisposes to hemorrhage and shock. He was placed in a low Fowler's position on his operative side thus allowing more freedom in breathing, promoting drainage, and relieving tension on the wound. However, he was not kept in this position for any length of time. At least every hour he was turned from side to side to prevent post-operative lung complications — e.g., atalectasis.

As the upper abdominal incision made breathing painful, Mr. Bruce had a tendency of taking short shallow breaths. Deep breathing was encouraged and stimulated by giving carbon dioxide and oxygen inhalations every hour for five minutes.

The following post-operative orders were carried out for the next few days:

Sedation — morphine gr. 1/6 q. 3-4 h., p.r.n.

Antibiotic therapy — penicillin and streptomycin 0.5 gm. t.i.d. (to prevent further infection).

Vitamin therapy — B-Plex 2 cc. b.i.d. and ascorbic acid 500 mg. I.M. q.d. (to improve his general condition and promote faster healing).

Oxygen therapy p.r.n. (for depressed respirations).

Early ambulation (to prevent pulmonary complications).

Water in sips only (to prevent post-operative distention).

Rectal tube and glycerin suppository (for gas).

I.V. therapy b.i.d. (to maintain fluid intake at a high level, especially as his was a biliary tract operation including the common duct).

Mr. Bruce had sips of water only at first. As there was little nausea and vomiting, the amounts were increased. The water balance was maintained by calculating the daily needs plus the output, including vomitus and bile drainage. A careful record of his intake and output was kept at all times.

To inform the surgeon how the common duct was functioning the color of the skin, urine, and stools was watched regularly. The skin and urine at this time were dark indicating that the obstruction was still present.

On the first post-operative day several laboratory tests were done. The white blood count of 21,500 showed some infection still present. His hemoglobin was surprisingly good — 98%. A slightly elevated N.P.N. of 44% showed the possibility of some renal impairment. Blood chloride at 480 mg. per cent was

below the normal of 570-620 mg. per cent showing that he was losing a large amount of NaCl in output and that more had to be given in his I.V. fluids to provide the normal balance in the blood stream. A serum bilirubin was done. This test measures the ability of the liver to excrete bilirubin. The normal is up to 8 mg. Mr. Bruce's at this time was 19.6 — somewhat elevated. This showed that the mechanical obstruction to the flow of bile in the intestine was not yet totally relieved. His carbon dioxide combining power was 49 volume %. This was below the normal of 55-75 volume % showing a lack of carbohydrate in his blood and the necessity of having it added in his I.V. fluids.

On the second post-operative day hiccoughs were very troublesome. Oxygen, given almost constantly, relieved him somewhat. His temperature remained elevated for a few days. Diaphoresis was quite troublesome and he complained of pain in his thoracic region, suggesting a post-operative pulmonary complication. A chest X-ray showed no sign of atelectasis or other involvement. He was made as comfortable as possible with alcohol rubs, sinapisms to his chest and sedation.

That afternoon his abdomen was somewhat distended. A Levin tube was passed and 510 cc. liquid (mucus and coffee ground fluid) was withdrawn from his stomach. An oil retention enema followed by a s.s. enema was given with the expulsion of much flatus. His abdomen became much softer and he felt relieved.

When the doctor changed the dressing for the first time, the incision appeared clean. Chloral hydrate in olive oil was given rectally that evening for Mr. Bruce was becoming tolerant to the other sedatives and they were ineffective.

On the third post-operative day Mr. Bruce was more active. He bathed himself and was up in a chair for ten minutes. He was tolerating clear fluids well with no emesis. He was, however, coughing up thick greenish mucus and phlegm. Jaundice was still apparent and his urine was dark. His T-tube drainage was working well.

On the sixth post-operative day Mr. Bruce's temperature was 102°, pulse 140, respiration 28. He complained of a tightness in his chest and his productive cough was more troublesome. He was given steam inhalations and sinapisms to his chest. His hiccoughs continued to be troublesome and his abdominal discomfort persisted. A Levin tube was passed and 600 cc. of very foul smelling, curdled fluid were withdrawn. These symptomatic nursing care measures made him more comfortable and his temperature came down to 99°. Considerable bile drainage was apparent at the site of the Penrose drain suggesting an accessory duct was untied. Chloromycetin 250 mg. q. 4 h. was started as the other antibiotics proved to be ineffective. Crude liver 2 cc. I.M. O.D. was now commenced.

Exactly one week post-operatively a great deal of bile drained from the centre of the wound. The skin edges gave way though the stay sutures held. This was precipitated by several days of severe, persistent coughing, hiccoughs, and the digestive action of the bile which drained profusely on the incision. The surgeon was notified and he packed the gaping area with sterile gauze dressing, irrigated it with tyrothricin, strapped the incision, and applied a binder to aid in holding the incision line together and allowing it to heal. It healed in seven days.

Mr. Bruce was placed on a soft, low-fat diet which he tolerated fairly well. His intravenous therapy was continued. Within the next few days his temperature returned to normal and there was no apparent oozing from his incision. However, his cough continued to trouble him and he was having abdominal discomfort. A flat plate of his abdomen showed no sign of an obstruction. The Levin tube was again passed and a Wangensteen tube established to keep his stomach empty of gas and fluid constantly. Large amounts of gas and light brown fluid were suctioned from his stomach.

Further laboratory tests were done at this time. The hemoglobin was 75%. The blood chloride was 400 mg. %. The serum bilirubin was 55 mg. % showing less jaundice. These tests showed some

improvement over the last ones except for the hemoglobin which was greatly reduced. He was given 500 cc. of blood.

Although Mr. Bruce had a satisfactory early post-operative period, considering the amount of liver damage, he looked toxic, sweating, vomiting from time to time, complaining of a steady low substernal pain, dyspnea and nausea. His white blood cell count returned to normal, his chest x-ray showed no evidence of chest complications. The liver function tests were normal except for an alkaline phosphatase of 18 per 100 cc. (the normal being 4-13 per 100 cc.). The increase was due to a continuing bile duct obstruction, preventing the phosphatase from being excreted normally. His pulse rate was 140. He was examined by a medical consultant and an electrocardiogram was done. It suggested myocardial enlargement and hypotoxemia. Digitalis gr. 1½ t.i.d. for three days and then once daily was ordered. It slowed and strengthened his heart and brought his pulse rate down to 108.

Mr. Bruce was continually asking for "hypos" even when he did not appear to be in pain. Placebos of normal saline were given and proved to be effective. None of the complications seemed to show anything definite and no adequate explanation could be given for any of them. Therefore, it was hoped that with good symptomatic nursing care his discomfort could be relieved and the rest left for nature to heel.

One morning some bright red blood with clots appeared in the suction bottle showing that there was fresh bleeding. Mr. Bruce was apprehensive and his pulse rate jumped. The suction was discontinued and 1,000 cc. I.V. with 20 mg. of Kavitan was immediately commenced to increase the clotting time. Blood and other I.V. fluids were given to replace the loss. By the next day the bleeding was controlled. It was not known where this bleeding came from but was believed to be from the operative area. The next day Mr. Bruce had 30 mg. of Kavitan. He was given sippy milk and high caloric fluids. Gradually his diet was increased to a high carbohydrate, protein, vitamin, low-fat diet. He still did not tolerate it very well.

During these days Mr. Bruce kept the Levin tube rolled up in his pyjama pocket and used it himself whenever he felt he needed to aspirate his stomach and relieve his abdominal discomfort. A choledochogram showed failure of the dye to enter the duodenum so that his common duct obstruction was still not completely relieved.

Mr. Bruce continued to make slow progress. The choledochogram made a month later showed the dye entering the hepatic ducts with a little getting into the intestines. The liver function tests showed an improvement also. His operative incision was healed but an incisional hernia was present.

Four months after admission, Mr. Bruce was up and about, his T-tube was draining into a small hot water bottle and he was discharged. Now, almost a year later, his obstruction is almost completely relieved and he is working again. He had his T-tube removed and liver function tests showed his obstruction relieved.

Nursing Care Problems

Some of the nursing care problems can be sorted out as follows:

1. Discretion was required in giving narcotics for this patient almost seemed addicted to them. It was necessary to know the difference between real pain and emotional upset. Every form of nursing care was attended to first, narcotics being used as a last resort. He was given an assortment of narcotics, analgesics, and placebos to help prevent addiction to any one drug.

2. The patient became very difficult and uncooperative towards the end of his stay in the hospital. It required great tact and patience to make him cooperate and have the necessary treatments.

3. Great encouragement was required to carry him along when his condition seemed so hopeless and he was so depressed.

4. It was very important to measure and record his bile drainage at the end of every eight-hour shift.

Health Teaching

Mr. Bruce's prognosis is fair to good, providing he will follow the

doctor's orders and exercise good health habits. The following are a few of the teaching points we stressed:

To make a gradual return to his work and strenuous exercise; to stay on a high carbohydrate low-fat diet; the correct way to care for his T-tube and drainage; to visit the surgeon as often as necessary; to report any unusual symptoms as elevated temperature, pain, etc., to the doctor immediately they occured.

In conclusion, I feel that caring for and studying Mr. Bruce's problems has added to my understanding of the vast number of details there are to learn about the surgery of the gall-bladder and biliary system. It has also made me realize what modern surgery and adequate nursing methods can do.

Parasites, Fish and Man

LEO MARGOLIS, PH.D.

THE WORD *parasite* is derived from the Greek *Mapaoltos* which literally means one who eats at the table of another. In biological terms it refers to an animal or plant that lives in or on another living animal or plant (called the *host*) at its expense. It may derive its nourishment by feeding directly on the tissues, including the blood, of the host or on the partially digested food of the host.

A parasite may cause anything from a little inconvenience to death.

There are thousands of species of parasites. Hardly an animal is completely free of them. Many parasites are even known to harbor other parasites. What an animal eats and where it lives largely determines the kind of parasites it accommodates.

Parasites can be divided into two broad categories — ecto-parasites and endo-parasites. The ecto-parasites live on the external surfaces of the host whereas the endo-parasites live internally. There is no part of an animal in or on which a parasite has not found a home. Examples of ecto-parasites are lice, fleas, mites, ticks, leeches, etc. Tapeworms, flukes, roundworms and protozoa (the causative organisms of malaria and sleeping sickness) are endo-parasites.

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The size of parasites varies considerably. Some intestinal forms are 30 feet long, others are less than 1/2,500 inch in diameter.

Man plays host to relatively few of the world's parasitic animals. Only about 100 species of internal parasites have been recovered from him. The life history and mode of transmission of these parasites vary considerably. About one-third have simple life histories, involving only one host; the rest have complicated life cycles requiring two or more hosts. In the latter category are the parasites that pass part of their life in animals that are eaten by man. Such animals are referred to as *intermediate hosts*. There are several parasites of man that utilize fish as intermediate hosts. These are found among the tapeworms (Cestoda) and flukes (Trematoda). The remainder of this paper will be confined to a discussion of the parasites that find their way into man via fish.

THE BROAD OR FISH TAPEWORM

The fish tapeworm, *Diphyllobothrium latum*, like all other tapeworms is a flat, ribbon-like, segmented worm. It ranges in length from 6-30 feet and has a maximum breadth of ½ to 1 inch. The anterior region is modified into a holdfast organ, or scolex, followed by a slender neck behind which occurs a series of segments like the links of a chain. There may be up to 4,000 of

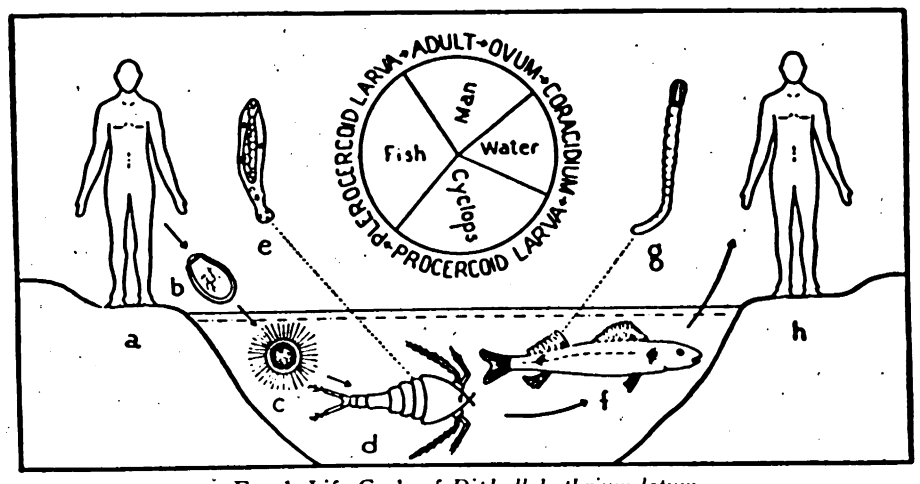

FIG. 1. Life Cycle of *Diphyllobothrium latum*

A. Man infected with adult tapeworms. *B*. Ovum passed in feces. *C*. Coracidium or ciliated free-swimming larva. *D*. Copepod ingests larva. *E*. Procercoid larva in copepod. *F*. Fish infected by ingesting copepod. *G*. Plerocercoid larva in fish. *H*. Man infected by eating raw fish. (From Belding, D.L., "Textbook of Clinical Parasitology." 2nd Ed. Courtesy Appleton-Century-Crofts, Inc.)

these segments each of which when mature contains a complete set of male and female reproductive organs. This parasite, as other tapeworms, lacks a digestive tract and obtains nourishment by absorption of nutrients through the cuticle.

The parasite occurs in the intestines of man and other mammals. The non-human hosts serve as reservoirs of the cestode. It is present in practically all northern temperate areas, but is abundant particularly in the Baltic countries. In Canada it occurs from the St. Lawrence Valley to British Columbia, with its main focus around Winnipeg. It is common in northern Michigan and Minnesota and has been reported in Alaska.

The life history involves a very small aquatic animal (a *copepod*) and a fish in addition to the mammalian host *(Fig. 1)*.

Eggs, at the rate of several million a day, are deposited in the intestines of the mammal. These are passed out in the feces and if they reach fresh water of a suitable temperature (60-75°F.), with sufficient oxygen, they hatch in about two weeks. Improper moisture, temperature, or oxygen conditions will retard development or kill the eggs.

The hatched larva or *coracidium* is ciliated, contains an embryo with hooks called an onchosphere, and swims freely in the water. It has a maximum free life of 12 to 24 hours. For further development it must be ingested by certain species of copepods. This is the first intermediate host.

In the copepod, the coracidium loses its ciliated layer, the onchosphere penetrates the gut wall and develops in the body cavity in 2 to 3 weeks, into an elongated larva, about ½ mm. long, known as a *procercoid*. Further development takes place only if the copepod host is eaten by a fish. This is the second intermediate host. Many species of fresh-water fish have been implicated, although not all species are suitable. In Canada, pike, pickerel, perch and sauger are the important hosts.

In the fish the copepod is digested and the procercoid migrates through the intestinal wall to the body cavity whence it may invade the musculature. The procercoid increases in size and the anterior end takes on the form of the adult scolex. This larval stage is called a plerocercoid and is usually less than ½ inch long. It develops in 1 to 4 weeks. Man becomes infected by eating raw or undercooked fish with plerocercoids. The fish is digested and the plerocercoid develops

into an adult tapeworm in the intestines in about 3 to 5 weeks.

The presence of the parasite in man may evoke various symptoms. They usually take the form of a mild intestinal disorder. Most cases are symptomless. If the individual is aware of the infection, he may suffer psychological disturbances. In the Baltic countries pernicious anemia has been associated with some infections. This has not been observed in North America.

The tapeworms can be eliminated by treatment with *oleoresin of Aspidium* or *carbon tetrachloride,* the former being the preferred treatment.

Prevention of human infection can be accomplished easily. The proper cooking of fish will kill the plerocercoids. Temperatures greater than 120° F. are lethal in a very short time. Proper drying, pickling or freezing at low temperatures are also lethal to plerocercoids.

The tapeworm is endemic in populations where raw or imperfectly cooked fish are habitually part of the diet. Positive diagnosis depends on finding the characteristic eggs or the discharged segments in the feces.

Several other tapeworms similar to *D. latum* have been recorded several times from man. These cestodes are normally parasites of other mammals or birds. Man is just an accidental host.

Liver Flukes

One family of flukes or trematodes, the Opisthorchiidae, parasitizes the liver of fish-eating mammals. Several species have been found in man.

Fish-transmitted liver flukes are flat, elongated creatures. They are 1/25 to 1 inch long and 1/50 to 1/5 inch broad near the middle and taper towards both extremities. In common with most other flukes, they are hermaphroditic, possess a sucker-like anterior and ventral adhesive organ and a digestive tract. They live in the small bile ducts and feed on blood and bile.

The species found most frequently in man is *Clonorchis sinensis,* commonly known as the Asiatic liver fluke, which is endemic in southeast Asia.

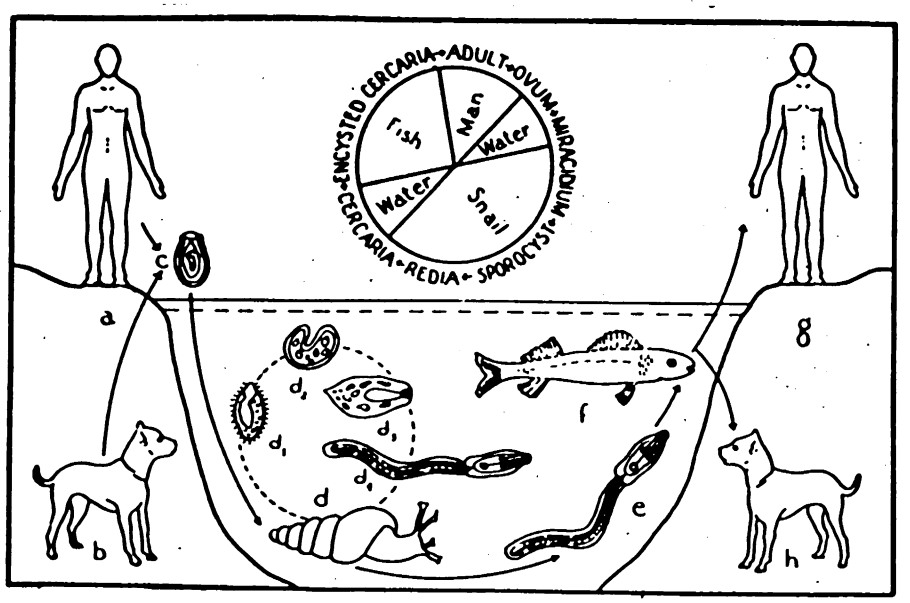

Fig. 2. Life Cycle of *Clonorchis sinensis*

A. Man infected with adult worm. *B*. Animal reservoir host. *C*. Ovum in feces. *D*. Metamorphosis in snail. (*d*'. Miracidium after hatching in intestine of snail. *d*". Sporocysts. *d*". redia. *d*'. cercaria). *E*. Free-swimming cercaria. *F*. Fresh-water fish with encysted metacercariae. *G*. Man infected by eating raw or insufficiently cooked fish. *H*. Reservoir animal host infected in similar manner. (From Belding, D.L. "Textbook of Clinical Parasitology." 2nd Ed. Courtesy Appleton-Century-Crofts, Inc.)

The infection has been found in North America in Chinese and Japanese immigrants but is not indigenous to this continent. It cannot become established here because of the absence of suitable first intermediate hosts. To complete its life cycle, the fluke requires a fresh-water snail as a first intermediate host and a fish-eating mammal as the final host *(Fig. 2)*.

The eggs are deposited in the bile ducts of the mammalian host, are carried into the intestines and passed out of the body in the feces. When ingested by suitable species of snails the eggs hatch in the intestine. The larva is known as a *miracidium*. It penetrates into the lymph spaces of the snail and undergoes a complicated process of development and asexual multiplication. Eventually a larval stage known as a *cercaria* develops and emerges from the snail. This stage is free swimming. If it is unsuccessful in finding the second intermediate host, a fish, it dies in 24 to 48 hours. The latter host, so far as is known, is always a member of the carp family. If a suitable fish is encountered, the cercaria penetrates under the scales and usually migrates into the meat, where it encysts. The cyst is very small, about 1/200 inch in diameter, and contains a larval stage called a *metacercaria*. If a raw or undercooked fish is eaten by man, the metacercaria excysts during digestion, migrates to the common bile duct and passes to the small bile capillaries in the liver, where the fluke matures in 2 to 4 weeks. It can live in man as long as 20 years.

Another species, *Metorchis conjunctus,* is found in Canada from the St. Lawrence Valley to Saskatchewan. Its distribution in Canada is apparently limited by its snail host. The fish host of *M. conjunctus* is the common sucker. Other species are not known to carry the metacercariae. The adults are found in man and several other mammals.

A few other species of the family Opisthorchiidae have been found in man and still others are potentially human parasites. All opisthorchiids have life histories similar to that of *C. sinensis,* but the species of intermediate hosts, particularly the snail hosts, usually differ.

The pathological effects of opisthorchiid infections are limited to the small bile capillaries. There is an increase in the connective tissue and the ducts become much thickened, with subsequent atrophy of surrounding liver cells. The extent of liver damage depends on the number of parasites in the bile capillaries.

Mild infections cause little harm, but heavy infections may bring about serious impairment of liver function and even death. Diagnosis depends on finding the characteristic opisthorchiid eggs in the feces. A satisfactory treatment has not been developed. *Gentian violet* has been used with some success.

Prevention in man is most successfully attained by proper cooking of fish before eating. Unfortunately in many of the endemic areas it is customary for the native populations to eat raw fish.

Intestinal Flukes

The family Heterophyidae is comprised of very small flukes that live in the intestines of fish-eating animals. In the adult stage they exhibit practically no host specificity. Most species can develop in birds as well as in a wide variety of mammals. About fifteen species have been found in humans in various parts of the world and many other species are potentially infective to man.

The life histories of all species are very similar to those of the fish-transmitted liver flukes. They involve a snail, a fish and a fish-eating mammal or bird. Some species utilize marine snails and fish as the intermediate hosts. Others have a fresh-water cycle.

The most important species found in man are *Heterophyes heterophyes* and *Metagonimus yokogawai*. The former species is found in southeast Asia, the Philippines, Egypt and neighboring regions. The cercariae develop in brackish water snails and encyst on the scales or skin or more rarely in the muscle of brackish water mullets.

Metagonimus yokogawai is a common parasite in the Orient. It has also been found in Egypt, parts of Europe

and Siberia. A trout-like fish and fishes of the carp family are the second intermediate hosts.

Heterophyid infections in man result from eating raw or uncooked fish carrying the metacercariae.

Light infections are usually harmless. However, very heavy parasite loads may give rise to intestinal disturbances. The parasite lies between the villi of the intestine and in man they may occasionally penetrate the mucosa. Since the flukes are covered with backwardly directed spines they are unable to back out. They die in the mucosa, liberate their minute eggs, of which some may be carried by the circulatory system to the heart where they settle and cause serious cardiac damage. Hemorrhage of the myocardium, accompanied by edema, is the commonest lesion. Thrombus formation may also occur.

Diagnosis of heterophyiasis depends on finding the eggs in the feces. It is difficult to distinguish the eggs of different species. There is no known successful treatment. Thorough cooking of fish kills the metacercariae and ensures protection against infection.

In all fish-transmitted parasitic infections of humans, infection results from eating raw or improperly cooked fish parasitized by the larval stages. Complete eradication of the parasite is impractical if not impossible, since it requires the selective destruction of an enormous number of animals.

However, theoretically, control in man depends solely on the proper cooking of fish before consumption. This appears to be a relatively simple matter. But, to the contrary, in areas where the parasites are endemic, this is a difficult procedure to put into practice since the native populations habitually eat raw fish or uncooked dishes prepared from raw fish. To educate these people to cook fish prior to eating is a most difficult task. They have been eating raw fish from the earliest times and probably will continue to do so.

Job Hints for Chapter Members

If you think your chapter meetings are dominated by a few leaders, don't blame them. Look at yourself. Each leader is playing his role as he sees it. But are you playing your role as a group member? That role need not be merely rank and file. Here is what you can do:

You can support others. When some member of the group presents a new idea or plan he invariably looks for clues as to its acceptance. If you agree or like what has been proposed, say so. The supporter and encourager are as important in a group as those who initiate new ideas or plans.

You can ask questions. This is no passive role. It is a creative role because it can bring about sounder thinking and better planning in a group. "What did the chairman mean by that statement?" you ask, and the chairman is forced to rethink his words. "Where are the facts to support that connection?" you ask, and the facts must be available or the argument falls.

You can sum up. Groups sometimes reach a point where their discussion goes in circles. This is the right occasion for you to recapitulate and say, "All right, we have reached this point. What's next?"

You can suggest compromises. When the group is split into factions and opinions are divided, the one who can reconcile differences and harmonize opposing views becomes valuable to the group.

You can release tension. When discussion gets heated, when tempers become edgy, you can throw in a light remark, a story. If well timed, such a contribution breaks the tension, helps group members regain their composure.

You can introduce a new idea. When group discussion runs dry, it is time for someone to throw in a new plan, a new way to solve a problem. No one has a monopoly on new ideas and yours may be as good or better than those of your colleagues.

— *The Teacher's Letter*

How awful to reflect that what people say of us is true!

—LOGAN PEARSALL SMITH

Public Health Nursing

The Public Health Nurse in the Health Service of a General Hospital

GLADYS CREELMAN

HAVE YOU EVER ASKED the question "What does a public health nurse do in a general hospital?" When I joined the staff in this capacity, I asked that question and attempted to find a quick answer by mere inquiry, only to learn that each hospital has its own individual answer. By describing the work here, I hope to give you an answer that may be workable elsewhere.

The Victoria General Hospital is operated by the Department of Health of the Province of Nova Scotia. There are 414 general beds and 50 beds used for poliomyelitis cases. There are no obstetrical or pediatric services.

For some years the hospital has had a health service, comprising both preventive and curative aspects for its employees. Two years ago this program was reorganized. All phases of it, as it affected patient and employee, were coordinated and placed under the jurisdiction of a newly organized Department of Preventive Medicine. This department has the same status as the various clinical departments within the hospital set-up. The personnel of the Department of Preventive Medicine consists of:

The head of the department, who is a physician with public health training and considerable experience in the public health field.

An associate member — the professor of epidemiology of Dalhousie University. He is also a physician with public health training.

A registered nurse with a certificate in public health nursing and experience in the public health and hospital nursing fields.

A secretary-stenographer who is responsible for records and clerical work.

The objectives of the department are directed toward the patients, employees and the environment in which they both exist.

Since the prime function of any hospital is the "care of the patient," I will first discuss the preventive health measures as they affect these individuals. Protection is afforded the patient by protecting the staff and safeguarding the environment but, in addition, other measures are carried out, which are directed specifically to the patients.

Hospital regulations governing the care and control of patients ill with communicable diseases are in effect. Questions that may arise from these regulations are usually submitted to the Department of Preventive Medicine for an answer.

We have found it very worthwhile to channel all laboratory reports through this Department, as in this way a clue to cases or suspected cases of communicable diseases is received, if such have not already been reported. It is the duty of the nurse to obtain any information required for reporting of these cases to the Department of Public Health. Since our patients come from all parts of the province, close liaison is maintained with the provincial Department of Health as well as the city Department of Health.

The Department of Preventive Medicine assumes responsibility for arranging the transfer of tuberculous or infectious cases to the special hospitals providing care. We supervise the rou-

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tine chest x-ray program on all patients admitted to hospital. All cases or suspected cases of tuberculosis are reported to the Department of Heath for follow-up.

Now let us consider the health services provided for employees of the hospital. All around us in business and industry we find a pattern of preventive medical services being developed. Hospitals have an excellent opportunity to set an example for the community, by establishing these services within the institution.

As in any large hospital, there are a large number of employees at the Victoria General Hospital and their duties are many and varied. They range from the man caring for the mice and frogs in the biochemistry laboratory to the girls operating the autoclaves in the central supply room; from the preliminary students to the internes; from domestic help in the dietary and household departments to the maintenance and technical staffs, to mention only a few. In organizing such a large heterogeneous group for the purpose of health services, considerable thought was given to an overall program, one that would be basically the same for all yet could be modified to suit particular groups. It was finally decided that the staff members should be grouped according to the type of work they were doing and the department in which they worked. For instance, it was not thought necessary to carry out the same immunizing procedures for clerks in the business offices as for student nurses. Consequently, for health service purposes the whole staff was divided into groups (five in all) and the basic program was arranged to meet the needs of the various groups.

All staff members have a chest x-ray on employment and each six months thereafter. There is no employment medical examination but use is made of the "Multi-phasing Testing Technique." The form used is similar to the questionnaire employed by insurance companies. New employees report to the Department of Preventive Medicine on the first Wednesday afternoon following employment. The health query is completed with the aid of the public health nurse. She learns a good deal about the employees by going over the questions with them. If it is found that a condition exists or did exist that requires assessment, referral is made to an appropriate out-patient clinic. After the questionnaire is completed, such immunization procedures as are essential are carried out.

A staff health clinic is carried on in cooperation with the out-patient department. This clinic is held daily from 9:00 to 10:00 a.m. Here all minor illnesses and ailments are treated. A person with a more serious condition is referred to the appropriate out-patient clinic. Attendance at the clinic is not compulsory. The employees may go to their own physicians but they are then responsible for any financial obligations incurred. After 10:00 a.m. any employee reporting ill is directed to the Department of Preventive Medicine and the nurse arranges for medical attention.

The student nurses' health program is part of this service. The medical staff doctors rotate, each being on call for a month at a time. There is a 14-bed infirmary for nurses in the residence. A graduate nurse is in charge of the infirmary and works in close harmony with the public health nurse.

I mentioned before that the environment of the patients and staff is safeguarded. Of course, there are modern plumbing and sewage disposal facilities and chlorinated water is used. Pasteurized milk and cream are provided and weekly reports are received from the city Department of Health on samples taken. Proper refrigeration and dishwashing facilities are available.

Sight is not lost of the desirability of having a program of health education. The public health nurse takes advantage of the visits of the staff to the health clinic to give individual instructions. She takes part in the lectures on community health and welfare given to the student nurses. Students in the outpatient department spend some time with her as part of their training.

This is but a brief résumé of the work carried on by the Department of Preventive Medicine and will only partly answer the question I asked in my first sentence. Time and space do not permit me to take you to the laundry to find out why Joe has not has his semi-annual chest x-ray or to answer the call that Susie is in her room in the staff residence and will not waken (Susie is a known diabetic) or even to sixth floor of the hospital to find out more about the patient whose chest x-ray reports look suspicious of tuberculosis. I can assure you though, that the work is interesting with very few dull moments. But then a public health nurse, wherever she is, finds her work is full of variety so perhaps that is the answer to the question.

A Toast to Canada

IN PROPOSING THIS TOAST, it is customary to dilate on the inexhaustible resources of Canada, its boundless wealth of mines and forests and fisheries, its rich soil, its vast industrial growth. This I shall not do. For such things have nothing to do with the greatness of a country.

England was a small and circumscribed land of uncertain resources when its people lit a torch to guide the world. Scotland was poorer still in Nature's gifts — so poor its sons had to go forth bearing the light of religion, the love of learning, the virtues of industry and thrift to deeply color the life of Canada.

No land was ever great because its people were able to wallow in luxury and lead easy lives. Rome perished at the height of her illusory magnificence when the stern spirit of justice, of orderly law, of faith resolutely kept, gave place to the material clamor for "panem et circenses."

What real greatness Canada possesses is its heritage from adventurers who, seeking new knowledge or new opportunities, dared unknown trails and rivers; from pioneers who, seeing comfortless clearings walled in by forests, set themselves to make farms and homes; of brave men who, menaced by alien conquest, held their land in an allegiance they believed was right; of patriots willing to be called rebels that the contagion of British liberties might spread to Canada.

It is the product of those who sought not ease but achievement; who spent themselves to duplicate here the farms, the industries, the churches, the schools, the useful institutions, the free ideas of other lands; who did not seek the easy way but, in response to some mysterious divine call, chose to travel the hard way.

When that spirit is drowned in the ease of constantly shorter working hours and constantly increasing luxuries, Canada is not achieving greatness but forgetting it.

The hope of Canada, in the years to come, is a constantly recurrent rebirth of the spirit which sees a far vision, not of complacent comfort but of hard-won achievement; and which, counting not the cost, follows that vision to the trail's end, whatever that end may be.

— VICTOR LAURISTON, *Chatham, Ont.*

How To Get More Sleep

Ten hints on how to sleep well are given by British science writer, Chapman Pincher, in his new book, "How To Get More Sleep." He advises: Shed your worries before you shed your clothes; go to sleep early enough to get all the sleep you need; go to bed with a satisfied but not overburdened stomach; ensure complete darkness in the bedroom; fix that dripping tap; take pains to make yourself as comfortable as possible in bed; never count sheep; try deliberately relaxing your muscles; try to convince yourself that you will go off to sleep; if you still have a few bad nights, don't worry, and do not be scared to take sleeping drugs if these are prescribed by your doctor and you keep meticulously to his dosage.

— *Science Information Service*

* * *

For children and youth, dancing in the parlor or on the green may be a very pleasant and healthful amusement, but when we see older people dancing we are ready to ask with the Chinese, "Why don't you have your servants do it for you?"

— SIR JOSHUA REYNOLDS

Industrial Nursing

Industrial Relations

LOUIS-PHILIPPE BRIZARD

BY INDUSTRIAL RELATIONS we mean all the communications that are set up between employer and employee to secure an industrial peace. As industrial organisation is as much an economic entity as a social one, working relations are essentially social relations. The personnel program is none other than an active plan, equally understood by management and employee, which helps them both to attain the aims and ends of their enterprise by:

1. Permitting the marketing of the product or function at less cost.
2. Increasing the satisfaction of the workers on whom the industrial organization rests.

Every function of the personnel program (medical services included) must meet the general aims and ends mentioned above, as well as specific ones. To attain good working relationships, the personnel program, as well as the medical service, must function by councelling not as authority. The personnel manager or the director of the medical service is an adviser to the Board of Directors of the enterprise on all questions pertaining to his services. The Board cannot free themselves of their proper responsibilities in this sphere and must not divide their authority by placing these specialists on the same level of authority. The personnel manager or the director of medical services has the responsibility of preparing a budget that will demonstrate to the Board of Directors the costs of operating their service.

The following obligations belong equally to the personnel and medical service:

1. The necessity for these services to fill in, with their specific aims, the objective aims of the enterprise.
2. The necessity for these services to act only as counsellors.
3. The importance of budgeting these services in order to realize better results in their functions.

Les Relations Industrielles

LES RELATIONS INDUSTRIELLES, ce sont tous les rapports qui s'établissent entre le patron et l'ouvrier, et qui assurent la paix industrielle. Comme l'organisation industrielle est à la fois une entité économique et une entité sociale, des relations de travail sont essentiellement des relations sociales. Le programme du personnel lui-même n'est donc qu'un plan d'action conçu par le "Management" pour l'aider à atteindre les objectifs de l'entreprise:

1. La mise sur le marché du produit ou service au moindre coût.
2. La satisfaction de la société de travailleurs sur laquelle repose l'organisation industrielle.

Tout service du personnel comme le service médical d'ailleurs doit donc rencontrer les objectifs généraux ci-haut mentionnés en plus de ses objectifs spécifiques. Pour atteindre sa fin, le programme du personnel, comme encore celui du service médical, doit remplir les fonctions de conseil et non d'autorité. Le gérant du personnel ou le directeur du service médical est un aviseur auprès de la haute direction de l'entreprise sur toutes les questions qui relèvent de sa compétence. La haute direction industrielle ne doit pas se dégager de ses propres responsabilités dans ces domaines et ne doit pas morceler sa ligne d'autorité en plaçant ces spécialistes sur la ligne même d'autorité. Le gérant du personnel ou le directeur du service médical a la responsabilité de préparer un budget qui renseignera la haute direction sur les coûts d'opération de son service.

Les trois points que j'ai développés devant vous sont ceux qui, à mon avis, s'appliquent également tant au service du personnel qu'au service médical, à savoir:

1. Nécessité pour ces services de remplir en plus de leurs objectifs spécifiques les objectifs généraux de l'entreprise.
2. Nécessité pour ces services de remplir uniquement les fonctions de conseil.
3. Importance de budgeter ces services.

A Nurse Looks at Public Relations

DOROTHY M. DENT

AS A "TYRO" to the Public Relations Program Committee, I should like to put my thoughts into words.

Human relations is a way of life — true! But it is also a way to happiness — for yourself and those with whom you come in contact. Therefore, if you have not an innate ability to sell yourself (the commodity) and your services (the product) to the consumer (the public), it is an aptitude that can be acquired through study and appliance of a good public relations program.

In selling the *nurse* to the public we find her in many settings and, therefore, the method used for each may vary somewhat. For example, due to the shortage of active nurses the one in private nursing can no longer be hired merely because the patient wants an audience. Allocation of a nurse now rests with the physician and someone in authority in the hospital. The demand exceeds the supply but it still remains that the "excellence of performance" is the yardstick for the marketing of this service.

The nurse in industry is no longer thought of as merely a first-aid worker. She is now a part of the total Industrial Relations program and recognized as an asset to increased production. The nurse acts as a liaison between employer and employee and thus becomes a "Public Relations Officer in Nursing" in the business world.

In order to sell your product you must know it and appreciate its value to the other person. This value must be tangible and willingly accepted by those needing the service — "a man convinced against his will is of the same opinion still." The commodity to be sold is a human one and the services are the composite of human relations in its entirety. The individual not being a creature of logic, but made up of fears, prejudices, desires, hopes and ambitions, a certain amount of emotionalism must be injected into our appeal.

It has been said that the way to "put a thing across" is to stimulate competition, not in the sordid money-grasping way, but in the desire to excel. It, then, becomes a challenge — an infallible way of appealing to those who require our services. Taking "bedside nursing" as a foundation for the profession, let us combine in all other spheres the kindness and efficiency needed in sickness, adding patience, tolerance, understanding, and interest in dealing with the problems of the physically well who need our help.

So many of us in the nursing profession, as in all other walks of life, forget where public relations have their beginning — among us, of the profession. Envy, jealousy, an overabundance of aggressiveness and ambition will result in the inability to form this unification, this oneness which ultimately should result in a local, a provincial, and a national team. Without this singleness of purpose we increase the difficulty of selling the profession. We become vulnerable to criticism. We find a lack of acceptance of us, as a commodity for the preservation of health and service in sickness.

Miss Dent is a nursing counsellor with the Department of National Health and Welfare, Ottawa.

Institutional Nursing

The Present Status and Needs of Nurse Instructors

SISTER DENISE MARGUERITE

THIS PAPER DESCRIBES a study whose purpose was to obtain information about nurse instructors that "would contribute to an over-all appraisal of the status of teaching personnel in Canadian schools of nursing." It does not set up criteria nor measure, against any given criteria, quality of teaching personnel. It is thought that an approximate estimate of present resources may have practical value as a basis for planning in the development and maintenance of a competent group of nurse teachers.

Through the years prominent nurse leaders have emphasized the importance of the nurse instructor, the responsibility entrusted to her, and the confidence placed in her. This observation is confirmed by quotations from various authoritative works written by competent people, starting with Dr. Weir's *Survey of Nursing Education in Canada of 1932* and covering the time up to *Nursing Schools at the Midcentury, 1950.*

This study is confined to full-time nurse members of the instructional personnel in hospital-controlled schools of nursing in Canada and to those schools and instructors who volunteered to participate.

From a total of 176 schools of nursing in Canada, 100 were selected and attempts made to obtain an adequate representation from each province. None of the schools employs less than two full-time instructors. The size and total number of schools per province in relation to the population were also considered.

Sister Denise Marguerite is director of nursing at St. Paul's Hospital, Vancouver, B.C.

A letter outlining the proposed study was sent to the directors of the 100 schools, asking for their cooperation and that of the instructional staff. Of these, 58 replied that they would cooperate. To eliminate duplication, two questionnaires were prepared — one for the director of the school regarding policies, organization, facilities, and general conditions; the second, for completion by the individual instructors related directly to teaching functions. Responses were received from 34 directors and 180 instructors, representing a total of 44 schools through all the provinces from British Columbia to Nova Scotia inclusively.

One of the limitations of a study of this nature lies in hazards implicit in the interpretation of the data. Some of those due to biased or inaccurate response were, to some extent, eliminated by the author's previous knowledge of some situations, and relationships found between data obtained from directors and that sent in by instructors in the same school. Another consideration regarding the reliability of the study might be this: if all the blanks had been returned, might the total picture have been significantly different? Is it possible that there was a definite relationship between response or the lack of it, and existing conditions? Responses did not include all the nurse instructors of respective schools, which might be taken to mean that those who considered their qualifications and preparation inadequate preferred not to respond. On the other hand, there were situations where the contrary was also true. So interpretations are subject to overestimation as well as underestimation. The relative and restrictive quality of all findings

must be constantly borne in mind.

A search for pertinent literature revealed that there has been, to date, no record made of any investigation of nurse instructional personnel in nursing schools. The only surveys made have included information regarding instruction but only indirectly have they dealt with the status of the teaching staffs.

In Canada, the Weir Report provided the first information regarding nurse education. Its recommendations urge:

> An increase in the number of qualified full-time instructors; more adequate pedagogic and post-graduate training for the average instructor; salaries of instructors equal to that of high school teachers of the same experience; greater attention to teaching methods; and adequate liberal as well as technical education.

Other writers, in the next two decades, make more definite recommendations with much concern for instructional personnel, their numbers, and preparation. Studies have been made in other countries which, though not directly affecting the position in Canada, have to some extent influenced its thinking. Without exception, committees and individuals investigating nursing education agree that "standards should be formulated to govern the appointment, status, qualifications, teaching and administrative loads of instructors." The evaluation program for schools of nursing in the United States places great emphasis on faculty competence, preparation, and organization.

The findings of the study may be summarized as follows:

1. Education requirements formulated by Dr. Weir in 1932 have been reached and surpassed by 72 per cent of the participants in this study.

2. None of the instructors had less than a high school diploma or junior matriculation on entering the basic course. Fifty-three per cent had senior matriculation or other types of preparation beyond normal school entrance.

3. Fifty-two per cent have credit for one to two years of university work; 22 per cent have baccalaureate degrees in nursing, and 1 per cent have master's degrees. Unfortunately there are still 5 per cent of instructors with no preparation beyond basic nursing, and a further 20 per cent with certificates from post-graduate clinical courses which in no way prepare them for teaching.

4. One hundred and forty of the 180 participating nurses stated that they would be interested in advanced study but listed the obstacles. The major one, named by 60 per cent of the group, related to finances.

5. The trend toward post-graduate study has been most marked within the past six to eight years.

6. Seventy-two per cent felt that their most valuable experience in preparation for an educational position had been general staff, head nurse, and assistant head nurse positions.

7. The median tenure in present positions was considered to be 14 months. The major reason for change, stated by 57 per cent, is advancement to better educational or professional responsibilities.

8. Sixty per cent of instructors reported that their responsibilities included administrative duties; 55 per cent reported counselling activities; 55 per cent have secretarial functions; and 17 per cent some type of student committee work.

9. The lecture and discussion method of teaching was used by over 80 per cent of instructors; 63 per cent used visual aids routinely; 35 per cent used the laboratory; and 16 per cent field trips. Projects and term papers were the most common form of assignment and the annotated bibliography was used by less than 7 per cent.

10. Forty-one per cent reported problems relating to presentation of material; evaluation, 28 per cent; planning, 24 per cent; interpersonal relationships, 7 per cent.

11. Total contributions to nursing literature by the group are 33 book reviews, 23 articles, and 3 books.

12. A large majority stated that time, facilities, and opportunities for professional reading were inadequate.

13. Nurse instructors' chief needs, by their own estimation, are for: in-

service education; better organization; greater numbers of better prepared instructors; more opportunity for self-expression; and more competent leadership.

Recommendations

Investigation, analysis, and experimentation at local levels recommended as a point of departure for attacking problems of greater issue at regional and provincial levels.

The analysis of teaching assignments, in relation to subjects taught and areas involved, points up an urgent need for reorganization or redistribution of activities among instructors. Centralization of programs is recommended on an experimental basis for smaller schools.

Investigation and analysis of nurse instructors' activities recommended with a view to establishing standards governing teaching and administrative functions of instructional personnel, and to determine the extent to which additional duties are a contribution to development of the nurse instructor.

Examination and study of the present system of advanced professional education indicated, with a view to making post-graduate study more readily available to nurses during summer sessions or on a part-time basis.

Formulation of definite policy regarding leave of absence for advance study is needed.

In the Good Old Days

(The Canadian Nurse — July 1914)

"It will be admitted that the average general nurse personnally dislikes to be called on to care for sufferers from acute mental diseases. The higher rate of wage which the nursing association considers is fitting for the nurse in charge of a mental case proves that nurses have decided mental disease is one of the most serious and trying maladies that can engage your ministrations. . . But while this position is entirely defensible from the standpoint of the law of supply and demand, is it so as regards the knowledge of mental disease and its care by the average nurse? I would suggest that if the general nurse receives $3.00 per day for nursing a case of which she knows a great deal, she should *pay* at least $6.00 a day to the family which permits her to nurse a case of insanity among its members, for it is a disease about which she knows nothing!"

* * *

"For the sake of the experience they would gain student nurses might be sent out from city hospitals to rural districts to nurse in the homes of families, far from medical care, who cannot afford to pay for such services."

* * *

"The public health nurses of the Department of Public Health in Toronto have been increased to 32 for the four summer months in order to assist in preventing the unnecessary waste of infant life during the hot weather."

* * *

"The Canadian National Association of Trained Nurses in endeavoring to formulate plans by which it will assume the ownership of our national magazine, *The Canadian Nurse*. This will be a long step forward for the National Association, indeed, we may say, the first step which really stamps the Association as national."

* * *

"It is estimated that in 70 to 80 per cent of the cases of feeble-mindedness the causes can be traced to heredity. Again, it has been estimated that one in every 500-700 persons is seriously feeble-minded. The time is not far distant when we will have to grapple with the problem these figures present."

* * *

Recently, a French scientist reported that iron-deficiency anemia can be effectively treated with transfusions of concentrated red blood cells. An advantage of this over other treatments, he said, is that the red cells given in transfusion not only replenish the blood, but their iron content is utilized by the patient's bone marrow to produce more red blood cells.

Aux Infirmières Canadiennes-Françaises

Au Chevet du Malade Tuberculeux

Jacqueline Ouimet, B.Sc.Ed.

Récemment je lisais dans un article la citation suivante: "Le chevet du malade est une chaire d'enseignement et l'infirmière en est le professeur."

Pour que l'étudiante puisse devenir cette éducatrice, elle doit donc acquérir durant son cours une formation morale et professionnelle intégrale. En tuberculose, il est évident que dans un hôpital général les ressources cliniques sont limitées et l'étudiante ne rencontre pas beaucoup de tuberculeux mais il s'en glisse toujours tout de même. Le dépistage de ces malades dans les services de médecine est donc précieux pour que son expérience soit parfaite et complète car il ne faut pas oublier que l'étudiante d'aujourd'hui est l'infirmière professionnelle de demain.

À l'école des infirmières, l'étudiante a reçu en classe des cours sur la tuberculose, principes de bactériologie, d'asepsie, d'hygiène personnelle et publique, de diététothérapie, de soins de nursing, des notions de psychologie, sociologie, pathologie et thérapeutique médicale.

C'est au département, sous la direction et le contrôle d'une monitrice, hospitalière ou institutrice clinique, tout dépend de l'organisation de l'hôpital — qu'elle peut appliquer dans la pratique ses principes théoriques car là l'enseignement est dirigé vers le malade plutôt que vers la maladie. Mais c'est encore plus précisément au chevet du malade, en travaillant *avec* l'institutrice clinique qu'elle peut comprendre et apprécier davantage l'aspect social de la maladie, son importance, les problèmes particuliers des tuberculeux et le rôle de l'infirmière professionnelle dans le traitement de la tuberculose. C'est là qu'elle développe son habileté dans les soins du nursing au tuberculeux, apprend à éduquer le malade et apprécie l'intervention du service médico-social. C'est aussi près de lui qu'elle se familiarise sur les méthodes employées dans la prévention et le contrôle de la maladie. En étudiant le malade qui souffre de tuberculose, elle s'habitue à faire de ses soins aux malades un service individuel, familial, social; elle le voit souvent entouré de sa famille et elle peut ainsi atteindre les membres qui la composent.

Dès que le diagnostic de son malade est posé, aidée de son institutrice, elle prépare son plan de travail afin d'être en mesure de donner à son malade des soins efficaces dans sa première expérience avec un tuberculeux. En le rédigeant, elle se rappelle les principes déjà vus en classe. Sa première pensée est donc de voir à isoler son malade suivant les facilités de l'hôpital. Puis, revisant ses connaissances déjà acquises, elle se souvient qu'une technique aseptique doit être instituée sans délai. Elle sait déjà qu'elle doit toujours, dans les cas de contagion, se servir d'une blouse pour approcher le malade. C'est l'institutrice qui lui montre comment la revêtir, comment disposer du linge contaminé dans un sac spécial, qui lui explique la méthode adoptée par l'hôpital pour la désinfection de la vaisselle, des ustensiles, des mains et lui enseigne la façon de procéder pour détruire les restes d'aliments et les expectorations.

Au départ du malade, guidée par son institutrice, elle s'initie à la technique de l'hôpital dans la désinfection terminale.

Ensuite, l'étudiante lit les prescriptions du médecin. Elle connait déjà l'importance de la thérapeutique médicale, aussi est-elle fidèle à donner les médicaments prescrits. Ici, elle se renseigne davantage sur les médicaments

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employés en tuberculose, les effets attendus et les symptômes possibles d'intolérance.

L'institutrice clinique attire également son attention sur les principaux points qu'elle doit observer chez son malade et noter au dossier: température, poids, notes sur l'appétit, fréquence de la toux, quantité et apparence des expectorations, réactions du malade aux visiteurs.

Parce que le traitement est long, il présente certains problèmes quant à la diète. L'étudiante étudie les goûts de son malade; elle en fait part à la diététiste. Elle apprend avec celle-ci que la diète du tuberculeux doit être substantielle et variée, tout en évitant de suralimenter le malade de façon excessive. Elle s'habitue à lui présenter des cabarets attrayants.

La technique d'isolement installée, les ordonnances médicales remplies, la diète établie, l'étudiante se souvient que la mesure la plus importante est maintenant d'empêcher la diffusion de la maladie en éduquant et en surveillant bien son malade. C'est là une partie importante de sa responsabilité. Pour atteindre son but, elle s'ingénie à comprendre ses réactions. Généralement, celui-ci ne prévoyait pas son diagnostic; il est désemparé. Elle doit donc l'approcher avec beaucoup de psychologie, de compréhension afin de l'aider à accepter sa nouvelle vie. On lui a déjà dit que c'est souvent après avoir montré son habileté comme infirmière que le malade est disposé à l'écouter. L'étudiante lui donne donc un bain d'éponge, l'installe confortablement tout en causant avec lui afin de gagner sa confiance.

Toujours guidée par son institutrice, elle commence l'éducation de son malade. Elle sait que l'enseignement de l'hygiène personnelle est de la plus grande importance. Elle lui explique donc que les sécrétions de sa bouche et de son nez sont une source de danger pour tout le monde et elle l'amène à comprendre que c'est seulement par sa collaboration qu'il protégera son entourage. Par conséquent, elle lui montre comment tousser, couvrir sa bouche, disposer de son Kleenex. Elle lui fait comprendre la nécessité de se laver les mains avant les repas, après s'être porté les mains à la bouche, avant de recevoir un visiteur. Elle parvient aussi à lui faire accepter l'importance du repos physique et mental. Un autre problème surgit bientôt pour l'étudiante: les visiteurs. Elle s'initie donc de plus en plus à son nouveau rôle d'éducatrice. Elle explique à son malade qu'il doit empêcher ses visiteurs de se contaminer à son contact; elle lui fait comprendre que le baiser est interdit, que ses visiteurs ne doivent pas toucher à ses effets personnels, ni boire dans son verre.

L'étudiante, tout en soignant son malade, s'habitue à le voir comme une personne humaine; elle constate l'interaction des facteurs spirituels, moraux, sociaux, économiques sur la santé. Elle comprend là l'importance de soigner tout son malade en le considérant comme un membre de la grande société humaine et non pas simplement comme un cas oubliant qu'il est une personne humaine, un membre d'une famille, d'un milieu, d'une société. Par conséquent, elle constate vite que seule elle ne peut pas réussir à lui enlever toutes les inquiétudes qu'il peut avoir au sujet de sa famille. C'est donc ici qu'elle entre en contact avec le service médico-social et apprécie son intervention. Déjà ce service a reçu une demande de placement dans un sanatorium.

La travailleuse sociale vient donc visiter le malade, l'encourager, l'orienter dans sa maladie, évaluer les facteurs physiques et psychiques et leur interaction chez lui, l'assurer que tout ira bien à la maison, que sa famille recevra une aide financière, si la chose est nécessaire, que les enfants seront placés dans des familles à la campagne sous la surveillance du service social. Le malade est-il inquiet de son travail futur, elle s'aperçoit que là aussi le service médico-social peut agir. La travailleuse sociale élabore déjà un plan de réhabilitation et va même jusqu'à lui affirmer qu'il pourra retourner à son travail à moins que celui-ci comporte trop de risques: excès de fatigue, heures trop longues, conditions hygiéniques non favorables, inhalations chimiques. L'étudiante note que la travailleuse sociale dresse au malade un plan d'instruction conforme à ses besoins individuels.

Cette intervention du service médico-social est une découverte pour notre étudiante qui souvent se demandait comment les tuberculeux pouvaient être aidés dans leur longue maladie et après leur retour à la santé.

Cet enseignement individuel, au chevet du malade, est généralement le plus employé et c'est aussi le plus efficace. Malheureusement, à cause du nombre restreint de tuberculeux dans un hôpital général, l'institutrice ne peut pas enseigner à chaque étudiante, en particulier, ce qu'elle veut et doit savoir sur ces malades. C'est pourquoi, en plus de cet enseignement individuel, l'institutrice profite du séjour d'un malade dans le service pour faire de l'enseignement clinique collectif aux étudiantes en stage dans le service de médecine.

Elle s'efforce de le varier pour le rendre plus intéressant et enrichir leur expérience. Pour atteindre ce but, elle tâche d'obtenir la participation active des personnes qui se rencontrent auprès du lit du malade: médecin, assistante sociale, diététiste, technicienne et surtout l'étudiante qui en prend soin. A cet effet, elle organise un symposium, ou, encore, un forum dont le sujet est le malade présentement dans le service et que toutes les étudiantes connaissent. Un autre jour, elle fera une démonstration des soins de nursing au tuberculeux, ou, encore, saisira l'occasion d'assister avec les étudiantes à un traitement spécial donné à un tuberculeux.

A ces cliniques, l'attention des étudiantes est attirée sur le fait que le bacille de Koch peut se localiser ailleurs que sur les poumons, soit sur les séreuses, viscères, ganglions lymphatiques, articulations, peau, etc.

L'institutrice donnera aussi cet enseignement s'il n'y a pas de malade dans le département. Pour les étudiantes, la clinique aura moins d'actualité mais elles recevront tout de même des notions sur la technique d'isolement, les soins du nursing, l'éducation du malade et l'intervention du service médico-social.

Quant au tuberculeux en chirurgie, l'institutrice clinique dans ce département fera l'enseignement dans le même sens avec en plus les soins pré- et post-opératoires.

A cause de la situation vivante où elle se trouve au chevet du malade et l'enseignement quotidien qu'elle reçoit, l'étudiante réalise encore plus le sérieux problème social de la tuberculose, la grande responsabilité de l'infirmière professionnelle dans le dépistage et le contrôle de la maladie et elle comprend que le nursing en tuberculose ne peut pas être envisagé sans penser à l'infirmière comme professeur.

Avec l'enseignement clinique, en médecine et en chirurgie, il est donc possible de développer chez elle une connaissance suffisante de la tuberculose et l'aider à comprendre sa responsabilité future dans la lutte contre ce fléau.

The nursing supervisor is in a position somewhat similar to that of the middleman in the field of commerce — the person who sees to it that the producer's goods are relayed to the retailer, who then serves the customer. In like manner, it is the responsibility of the nursing supervisor to see that the products of administration, such as policies and procedures, are relayed to the staff nurse who, in turn, serves the patient and his family.

If the consumer is not satisfied with the merchandise, word is passed to the producer and necessary changes are made. Similarly, if the policies governing the services to the patient do not meet his needs, the staff nurse tells the supervisor who, in turn, informs administration. Administration can then make the changes necessary to improve the situation.

— EMMA HARLING

A patient suffering from a serious heart ailment generally needs lots of rest. A growing number of experts, however, are convinced that the resting position should not be flat on the back, but sitting up. They point out that in the recumbent position, a patient's blood does not circulate as rapidly as it does with his head up and his legs down. Also, the patient's lungs cannot hold as much air.

Nursing Profiles

NURSES ALL OVER CANADA shared in the pride of their colleagues in Alberta when, at the annual convocation of the University of Alberta in May, **Rae Chittick** received an honorary LL.D. in recognition of the splendid contribution she has made to nursing in that province. Last year Miss Chittick transferred her interest to eastern Canada when she became director of the School for Graduate Nurses at McGill University. She has been well known by Canadian nurses everywhere since she served as president of the Canadian Nurses' Association in 1946-48.

Born in Ontario and educated in Calgary, Miss Chittick received her professional training at Johns Hopkins Hospital, Baltimore. She holds degrees from Teachers College, Columbia University; Stanford University and Harvard. For many years she was on the faculty of the School of Education at the Calgary Division of the University of Alberta.

DR. CHITTICK *in her academic robes following the convocation where she was presented for her honorary doctorate by* MISS HELEN PENHALE, *president of the Alberta Association of Registered Nurses and director of the School of Nursing, University of Alberta.*

Florence H. M. Emory, one of Canada's best known nurses who has received well deserved international recognition, has retired from the post she has held for the past 30 years in the School of Nursing, University of Toronto — professor of nursing and associate director of the School.

Born in Niagara Falls, Ont., Miss Emory received her basic training at the old Grace Hospital, Toronto. The following year she became a district superintendent with the Toronto Department of Public Health, becoming supervisor of school nursing three years later. She joined the School of Nursing in 1924 as assistant director, becoming associate director in 1943. Miss Emory is author of "Public Health Nursing in Canada," first published in 1945. Many hundreds of qualified public health nurses all over the world attest her abilities as a teacher.

Randolph Macdonald Eaton's

FLORENCE H. M. EMORY

Professionally, Miss Emory has always had a strong sense of obligation. She served as chairman of the Membership Committee of the International Council of Nurses for 20 years — 1933-53. Completing a three-year term as president of the Registered Nurses' Association of Ontario in 1930, Miss Emory was elected president of the Canadian Nurses' Association and filled this office effectively until 1934. In 1949 she became chairman of the Nursing Advisory Committee, Toronto Branch, Victorian Order of Nurses.

Miss Emory was made chairman of the Nursing Committee, Ontario Division of the Canadian Red Cross Society, in 1935 and held this office until three years ago when she became chairman of the National Nursing Committee, C.R.C.S. In recognition of all her energy and enthusiasm in this respect she was awarded the Florence Nightingale Medal in 1953 by the International Red Cross, Geneva.

A new interest has been added to all of the committee work Miss Emory hopes to continue — an attractive little bungalow with a garden. Nurses everywhere will wish her long years of happiness in her new surroundings.

Irene Iola Shaw has taken over her duties as superintendent of the Bowmanville, (Ont.) Memorial Hospital after spending nearly seven years as superintendent of the Peel Memorial Hospital, Brampton, Ont. A graduate of the Ontario Hospital, Brockville, Ont., Miss Shaw had occupied administrative positions previously at Lord Dufferin Hospital, Orangeville, and at the Ontario Hospital in Cobourg.

A somewhat different form of honor was conferred on **Lena Polischuk** by the Saskatoon Council of Women when she was recently nominated as "citizen of the year." Contracting poliomyelitis while a student nurse, Miss Polischuk completed her training despite the confining limitations of a wheel chair and is now on the staff of the isolation ward at the Saskatoon City Hospital.

A Sarnia nurse who has a long record of service, **Mrs. Mary Elrick,** was honored by the Sarnia Business and Professional Women's Club when they dedicated a room in the new General Hospital to her.

After graduating from the Sarnia General Hospital, Mrs. Elrick engaged in private nursing for 17 years then returned to her alma mater as supervisor of the medical department. She is a past district councillor of the Registered Nurses' Association of Ontario.

Sister Beatrice of the Protestant Sisterhood of St. John the Divine has retired as superintendent of St. John's Convalescent Hospital, Newtonbrook, Ont. The first superintendent, Sister Beatrice began her training in 1896 at the original St. John's Hospital, Toronto. The transfer to the convalescent hospital was made in 1937. **Sister Vera,** assistant superintendent for many years, succeeds her.

In Memoriam

Mary B. Beharrel, who graduated from the Vancouver General Hospital in 1908, died in November, 1953.

* * *

Mrs. John (McCulloch) Benson, a graduate of Lady Stanley Institute, Ottawa, died suddenly at Edmonton on April 21, 1954, at the age of 84. Following graduation, Mrs. Benson took a post-graduate course with the Victorian Order of Nurses. During her years of service with the V.O.N. she organized branches in Halifax, Winnipeg and Edmonton and opened a cottage hospital at Aylmer, Ont.

* * *

Annie Laura Campbell, who graduated from the Toronto General Hospital in 1913, died at Toronto on April 13, 1954. Shortly after graduation she enlisted with the C.A.M.C. She served in France with No. 4 Base Hospital, later serving on hospital ships in Greece, Serbia and Salonika. Prior to her retirement eight years ago she was a member of the staff of the Toronto Public Health Department.

* * *

Mary L. (Patterson) Cade, who graduated from the Moose Jaw General Hospital in 1918, died at Central Butte, Sask., in May, 1954.

* * *

Lucy B. Drummond-Hay, a former member of the Queen Alexandra Jubilee Nurses in Scotland, who was an honorary

parish nurse at Hondo, Alta., for 15 years, died at Victoria on February 26, 1954, at the age of 83.

* * *

Mamie (Brown) Hadfield, who graduated from the Vancouver General Hospital in 1916, has died.

* * *

Winnifred (Stewart) Jackson, who graduated from the Vancouver General Hospital in 1925, has died.

* * *

Alice (Wardell) Lauder, who graduated from the Vancouver General Hospital in 1906, has died.

* * *

Margaret MacLellan, who graduated from the Amasa Wood Nurses' Training School, St. Thomas, Ont., in 1905, died suddenly on April 4, 1954, in her 86th year. Since her retirement 25 years ago, Miss MacLellan had lived at Poplar Hill, Ont.

* * *

Doris (Burd) McCulloch, who graduated from the Vancouver General Hospital in 1929, died at Vancouver on April 3, 1954, after a long illness, in her 48th year. Mrs. McCulloch took a deep interest in the work of hospital auxiliaries and for a time was president of their provincial organization.

* * *

Genevieve McDonald, a graduate of St. Vincent de Paul Hospital, Brockville, Ont., died on April 29, 1954, following a brief illness, aged 39. For a number of years Miss McDonald was a head nurse at the Jewish General Hospital, Montreal. At the time of her death she was a nursing counsellor with the Civil Service Health Division at Ottawa.

Flora H. (Stevens) McQueen, who graduated from the Winnipeg General Hospital in 1918, died on March 28, 1954. Prior to her marriage, Mrs. McQueen had served with the Victorian Order of Nurses.

* * *

Mary Marjorie Mulligan, a student nurse at Hotel Dieu Hospital, Windsor, Ont., died on April 13, 1954, following a brief illness, aged 20.

* * *

Marjorie Quinney, a graduate of St. Joseph's Hospital, London, Ont., was killed in the collision of the TCA North Star over Moose Jaw on April 8, 1954. Miss Quinney had been a stewardess with TCA for the past two years.

* * *

Elizabeth (McCabe) Regan, who graduated from St. Michael's Hospital, Toronto, in 1924, died on March 1, 1954. Mrs. Regan engaged in private nursing for two years before her marriage.

* * *

Anne (Dolan) Scully, who graduated from St. Michael's Hospital, Toronto, in 1908, died there on January 9, 1954. Mrs. Scully was one of the first nurses to volunteer her services in the disaster following the Halifax explosion in 1917.

* * *

Muriel Isabel (Howard) Stinson, who graduated from Royal Victoria Hospital, Montreal, in 1927, died suddenly on January 10, 1954. Prior to her marriage she had served as night superintendent at Chambers Memorial Hospital, Smiths Falls, Ont., and as operating room supervisor in the Great War Memorial Hospital, Perth, Ont.

Early ambulation does not mean sitting in the bedside chair. If walking is initiated early in convalescence the patient has not lost much strength and can usually ambulate easily. If his convalescence has been stormy he may need much support. On his early excursions out of bed, he should be supported by grasping him around the waist as he sits on the edge of the bed. He can then be stabilized as he steps to the floor and starts to walk. At this time, he should be taught the essentials of good standing and walking posture. This will ensure him good body balance as he walks, similar to that learned in crutch walking. He should be encouraged to take short steps with his feet not too closely together. After he has become more sure on his feet he may walk with the aid of a chair which he can push ahead of him. This chair should have a sufficiently high back so that he can walk in an upright position.

— GERALDINE SKINNER in *Nursing World*

To be honest and faithful is to belong to the only aristocracy in the world — and the smallest.

— ISRAEL ZANGWILL

News and Echoes

from

Your NATIONAL OFFICE

The R.N.A.B.C. Moves

BY NOW THE Registered Nurses' Association of British Columbia will be settled in to their new offices at 2524 Cypress Street, Vancouver 9. Congratulations are certainly in order as the green light was given them to go ahead with their building plans just a year ago. For a description of the facilities, we quote from their April *News Bulletin:*

> Members and guests will enter a waiting room which will be quiet, spacious, and, when furnished, should be comfortable and attractive. Conferences and interviews will take place in privacy, as each member of the professional staff will have her own office. Council and committee meetings will be held in a board room large enough to accommodate 35 people but which can be divided for smaller groups. Working space will be ample for present and some additional staff. A soundproof workroom will eliminate the noise of mimeograph and addressograph machines and provide adequate space for storage of supplies. Permanent records, such as the register, will be kept in a fireproof vault. A small staff room and kitchenette will be appreciated by all the staff and especially by the directory staff on evening and night duty.
>
> These fine new quarters should promote greater efficiency on the part of the staff and should facilitate the work of committees. The rental from the remaining space should carry the costs of the building, including maintenance and amortization of the mortgage. The building itself is conservatively modern and, it is believed, will create pride of ownership in our general membership.

Nurses' Accommodation in Winnipeg

A new building project in Winnipeg is providing nurses from the General Hospital with low rental apartments. The 50-suite block, built under the "limited dividend section of the National Housing Act," is said not to resemble a nurses' residence with the usual reception rooms and community facilities but is made up of two- and three-room suites. These will rent respectively for $40 and $50 a month. Such a plan would appear to be one solution to the serious problem of hospital personnel finding suitable accommodation at moderate cost. Although satisfaction through one's work is said to be the greatest factor in stabilizing employment, nevertheless comfortable and suitable housing can make the problems seem less burdensome.

Conference at Queen's

In May nearly 40 nurses who are connected with or vitally interested in nursing education met together for five days at Queen's University, Kingston. By means of informal discussions with members of the faculty who were in the field of general education, directly or indirectly, they were stimulated to apply some of the principles of general education to their own fields. This was not a series of lectures but an endeavor to present ideas and principles which are inherent in all forms of education. There were no words of wisdom from "nursing experts" but only the concept that one cannot be in a group without finding that each person in the group knows more about some phase than the others. Since nurses are a rather strongly disciplined group, working and often living in a traditional hierarchy, it took several sessions of discussion to obtain the free expression of opinion that was sought. As the conference will be written up at length for *The Canadian Nurse* at a later date, no attempt is being made here to present its outcomes. It is sufficient to say that the main issue — recognized by all but still unsolved — is: What do we wish to be the result of nursing education? In other words, what do nurses expect of nurses?

We would like to congratulate those responsible for planning the conference upon their departure from the usual in choosing a leader. Alan Thomas, assistant to Dr. Roby Kidd, director of the Canadian Association for Adult Education, went far in proving the theory that an able leader does not need to be an authority in the field of the specific discussions. An unbiased "referee" is often able to analyze a situation in a more farsighted manner as he is not hampered by prejudice or preconceived ideas.

Nouvelles et Echos

Des Logements pour les Infirmieres de Winnipeg

A Winnipeg l'on projette la construction d'une maison de rapport à loyer modeste pour les infirmières des hôpitaux généraux. Cet immeuble, construit "d'après une clause spéciale de la Loi Nationale de l'Habitation," contiendra 50 logis. Il n'y aura pas de ces salons communs que l'on trouve à l'ordinaire dans les résidences d'infirmières. Chaque logis contiendra deux à trois pièces qui se loueront respectivement $40 et $50 par mois. L'on croit par ce moyen diminuer les difficultés rencontrées par les hôpitaux concernant les infirmières. La satisfaction au travail est un facteur important dans la stabilisation du personnel; néanmoins un logis confortable trouvé au retour du travail aide à faire oublier les tracas de la journée.

Conference d'Etude a Queen's

L'Université Queen's de Kingston réunissait en mai dernier 40 infirmières intéressant tout particulièrement aux questions d'éducation. Durant cinq jours elles discutèrent familièrement des principes généraux de l'éducation pouvant s'appliquer aux infirmières. Il n'y eut pas une série de conférences mais l'on tenta de présenter les idées et les principes se rapportant au domaine de l'éducation.

Il n'y eut pas d'énoncés didactiques donnés par des spécialistes mais chacune réalisa qu'elle ne peut faire partie d'un groupe sans se rendre compte que chaque personne en sait toujours plus long que les autres sur un certain sujet. Les infirmières, étant un groupe très discipliné, habituées à vivre et à travailler sous une hiérarchie, ont éprouvé des difficultés à donner leur opinion et il a fallu plusieurs séances de discussion avant qu'elles s'expriment librement. *L'infirmière Canadienne* donnera prochainement un compte-rendu de cette conférence; nous ne nous étendrons donc pas sur le sujet. Qu'il suffise de dire que toutes ont reconnu que le fond de la question est que "Quelle formation devons-nous donner à l'infirmière?" est demeuré sans réponse. En d'autres termes: "Nous les infirmières qu'attendons-nous des infirmières?"

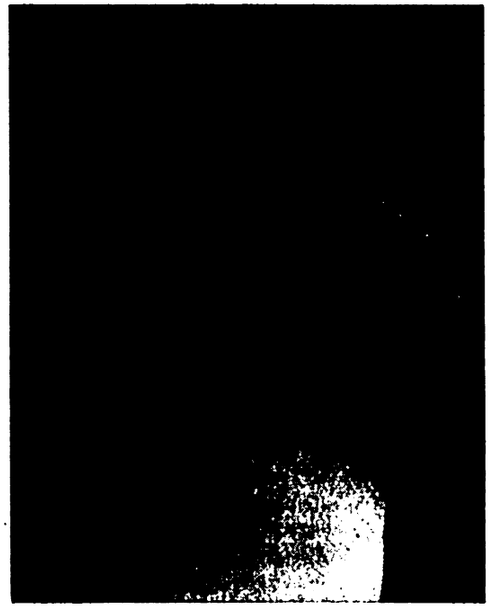
Nous félicitons les organisatrices de cette conférence qui contrairement à l'ordinaire n'ont pas pris pour chef un membre de la profession. M. Alan Thomas, assistant du Dr. Roby Kidd, directeur de l'Association Canadienne pour l'Education des Adultes, fut choisi. Il a prouvé qu'un homme qualifié, un chef habile qui ne fait pas partie du groupe intéressé, peut très bien réussir. "L'arbitre" est plus souvent en mesure d'analyser une situation et de prévoir, mieux que les partis intéressés.

L'Association des Infirmieres Enregistrees de la Colombie-Britannique est Devenue Proprietaire

L'A.I.E.C.B. est à s'installer dans l'immeuble qu'elle commençait à construire il y a un an. Pour la description des locaux voyez ce qu'en dit leur *Bulletin de Nouvelles* d'avril:

"En entrant, les membres de l'association et les visiteurs trouveront une salle d'attente vaste et tranquille et qui, une fois meublée, présentera un aspect accueillant. Les entrevues se feront privément et chaque membre du personnel professionnel aura son bureau. Les assemblées auront lieu dans une salle pouvant contenir 35 personnes. Cette salle peut se subdiviser pour accommoder des groupes plus petits. L'espace réservé aux autres membres du personnel est suffisant pour les besoins actuels et ceux de l'avenir. Une salle de travail à l'épreuve du son éliminera les bruits des machines à polycopier,

Doctors Agree on Carnation



So many doctors in Canada agree that Carnation Evaporated Milk is the food of choice for the bottle-fed baby.

THEY HAVE FOUND that Carnation is particularly digestible. And that a Carnation formula, giving *all* the nourishment of good, fresh milk plus 480 units of Vitamin D per pint, is excellent for the normal baby as well as for difficult cases — quintuplets, quadruplets, and triplets.

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PRESCRIBED FOR MORE CANADIAN BABIES THAN *ALL* OTHER BRANDS *COMBINED*

"from Contented Cows"

854

à adresser et logera les magasins pour la papeterie et l'outillage. Les dossiers permanents, tel que le registre, seront gardés dans des voûtes à l'épreuve du feu. En plus une petite salle de repos et une cuisinette feront la joie de tous les membres du personnel, particulièrement des membres chargés du registre des infirmières du service privé, lorsqu'elles travaillent le soir.

"Ce bel édifice contribuera à faciliter le travail du personnel et aidera également les divers comités. Une partie de l'immeuble est loué et les loyers suffiront pour défrayer le coût de la construction, l'entretien et le remboursement de l'emprunt. L'édifice a un caractère conservateur tout en étant moderne et fera l'orgueil des membres de l'association qui en sont les propriétaires."

Encouraging Breast Feeding

In *Nursing World* of November, 1953, Reva Rubin describes the service being given in England throughout the antepartal and postpartal periods, to encourage breast feeding. The care includes: early examination, diagnosis, and prophylaxis of the breasts; instruction of the mothers; and careful follow-up of those mothers presenting problems in lactation. The procedure followed at the British Hospital for Mothers and Babies at Woolwich is typical:

Each mother who registers for obstetrical care is seen at her first or second antepartal visit by a skilled obstetrical nurse assigned to breast care. A notation is made of the examination findings, diagnosis and treatment. If intensive follow-up is needed, a colored star is attached to the record. It then becomes a part of the antepartal chart and after delivery it is added to the infant's chart.

Breasts are initially examined for size, vascularity, suppleness of the skin, and condition of the nipples. The suppleness of the skin varies from mother to mother — the more supple the skin, the greater is the potential for expansion. Conversely, the tighter the epidermis, the greater the tendency for painful engorgement. Any deviation from normal in the nipples is noted. One that retracts on compression of the areola will have intensive treatment and follow-up. Mothers with lightly pigmented areolas usually experience tenderness or pain on nursing.

A history of previous lactation experience is taken from multiparous mothers. A culture is taken if there is any history of mastitis. Half of the mothers have been found to be capable of successful nursing without further treatment.

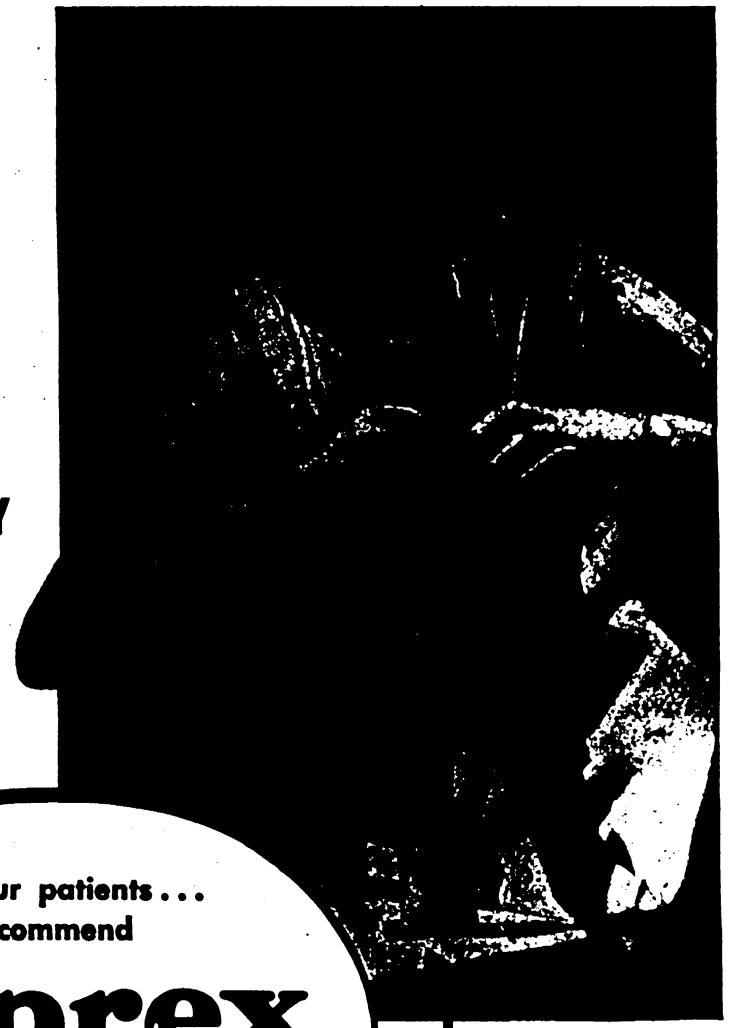
No treatment is instituted for those mothers whose diagnosis and prognosis for breast feeding is good but they are seen by the same nurse four weeks before the expected date of confinement. At this time areolar expression is demonstrated to them and they are advised to do it daily for five minutes. The object of routine prenatal areolar expression is to obtain a daily flow of colostrum that is neither sticky nor thick. It has been proved that colostrum that is not drawn off will cause blockage of the ducts. The breast massage movement is included to give the mother comfort and skill in the handling of her breasts. In those whose breast skin is not sufficiently supple, this treatment is started two weeks earlier.

Mothers with retracted, flat, or inverted nipples are seen during the fourth month and fitted with nipple shells. These fit tightly over the areola and leave an opening for the nipple. By gentle pressure on the nipple it becomes, over a period of time, protracted. The shells are made of glass and are very comfortable.

The nurses continue their interest in breast feeding throughout the lying-in period. To give them the time that is so necessary for the instruction, mothers who deliver on the same day are dispersed to different wards. During the first 48 hours after delivery, babies are put to the breast for one or two minutes, for a practice not a feeding period. If he needs feeding, the infant is given the expressed colostrum. The nurse in charge examines the mother's breasts before each nursing period for engorgement or nipple tenderness.

The mothers are taught to empty their breasts after each nursing period. This stimulates lactation and provides an abundance of milk. Treatments and the amount of expressed milk are recorded.

The Quick, Sure One-Treatment Method for HEAD and BODY LICE



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How to Keep Your Teeth

WE HAVE HEARD a lot lately about fluorine. The chemical has been introduced into drinking water because it is thought that it might help us — particularly the children — to keep our teeth longer. Although it is too early to say what the result may be, the evidence so far seems to show that children who drink water with fluorine in it have fewer cavities than those who drink water without it.

The mouth is a kind of chemical factory. It worked more efficiently in primitive times than it does today. Even now, people in areas that are not highly industrialized have far less trouble than we do with their chemical output.

Teeth are the chief sufferers from the attacks that the acids we produce in our mouths make upon us. The most common of these acid-makers is a group of bacteria that brings about fermentation of sugar and starches, releasing destructive acids to eat away the protective enamel of the teeth and to lay the tissue beneath open to infection. These are the same organisms that turn milk sour and ferment fruit.

Primitive people do not eat as much acid-producing food as we do and their food needs more chewing than ours. Chewing polishes the teeth, clearing away those particles which, if left between the teeth, stir the acid-making bacteria into action.

Tooth decay is a disease because it destroys normal tissue. It does not command dramatic headlines and it is not found on any list of chief causes of death. Yet it is the most widespread malady in the world. It can lead to intense pain, a toothless mouth, facial disfiguration, and to ailments in other parts of the body.

Professor Guttorm Toverud, dental health consultant for the World Health Organization, believes that nearly all young people in industrialized areas suffer from tooth decay. Almost all their elders suffer, in addition, from disorders of the gums and the body structures supporting the teeth. During World War II the U.S. Army found that more conscripts were rejected for dental disorders than for any other cause. In New Zealand, nearly half of the young men called up had artificial teeth and one-fifth were toothless.

The official view now is that it is hopeless to try to cope with the problem merely by filling cavities as they occur. The American Dental Society, for example, has estimated that if all the dentists in the U.S. worked at full speed repairing teeth alone, there would be six new cavities for every one filled. While the position is serious, medical science does not despair of finding a solution as it has for so many other problems. Research workers are concentrating on finding preventives for tooth decay. Some progress has been made, though much more remains to be done. The enamel-destroying acid is formed with very great speed — in fact, within five to 20 minutes after food has entered the mouth. We can help, therefore, by brushing our teeth immediately following meals, before the acid has been liberated.

Some people seem to be immune from decay. They have the capacity of producing in their mouths a natural ammonia compound that prevents the formation of acid. Attempts have been made to reproduce this natural armor-plating by using ammonia-liberating dentifrices. Should any effective substance be found, it will probably be applied with the toothbrush, so we can see how necessary it is for everyone to use the toothbrush properly and regularly.

Bad as tooth decay is, it is usually less serious than the diseases that affect the gums and the bony tissues surrounding the teeth. Infections such as gingivitis and pyorrhea are among the chief causes of loss of teeth. They occur mainly in elderly or middle-aged people but they can attack children and young people. It was true in the past that pyorrhea was a disease from which no sufferer was cured until he had lost all his teeth. Fortunately, this is no longer the case. This condition has been successfully treated with the new antibiotic drugs.

The best advice, at the moment, if you wish to keep your teeth, is to use the toothbrush faithfully and well, visit the dentist regularly, and keep to as wholesome a diet as possible.

—SIS: Medical Features

* * *

Something NEW has been added! → **Gerber's Meats for Babies**

High nutritive value! → Careful processing of Gerber's Strained Meats results in high retention of valuable meat-protein, B-Vitamins and minerals.

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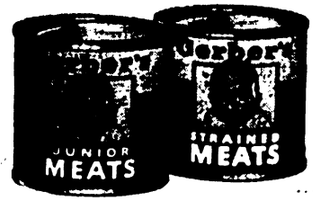
Babies are our business... our only business!



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Student Nurses

Peptic Ulcer

IRENE NORDWICH

MISS GORMAN, a 39-year-old office worker, was admitted to the public ward on March 25, complaining of nausea, vomiting, and intermittent pain in the episgastric region that increased in severity during the night. Pallid and very emaciated, Miss Gorman had first noticed a burning sensation and slight pain after meals six months previously. Her physician prescribed medication and a special diet which was carefully followed. After gaining five pounds, she felt so well she stopped taking her medicine and discontinued the diet. A month later, vomiting started again. She would feel well for days, then become exceedingly nauseated. The doctor placed her on a strict fluid diet and, as soon as a bed was available, sent her to hospital.

DIAGNOSIS

A barium series of x-ray plates revealed a duodenal ulcer with pyloric obstruction.

A peptic ulcer is an excavation formed in the mucosal wall of the stomach, in the pylorus or in the duodenum. It is due to the erosion of a circumscribed area of the mucous membrane. This erosion may extend to the peritoneum. Peptic ulcers are more apt to be in the duodenum than in the stomach but, whether on the gastric or the duodenal side, most of them occur near the pylorus, a few being situated in the pylorus itself. As a rule they occur singly but there may be a number of them present at once.

The etiology of peptic ulcer is poorly understood. The disease occurs with the greatest frequency between the ages of 20 and 40 but has been observed in childhood, even in infancy. It seems to develop in persons who are emotionally tense but whether this is the cause or effect of the condition is uncertain. Predisposing factors most important in the development of peptic ulcers are: irregular eating habits, overindulgence in alcohol, and the season of the year, for this disease tends to appear and recur must commonly in the spring and the fall.

PERSONALITY

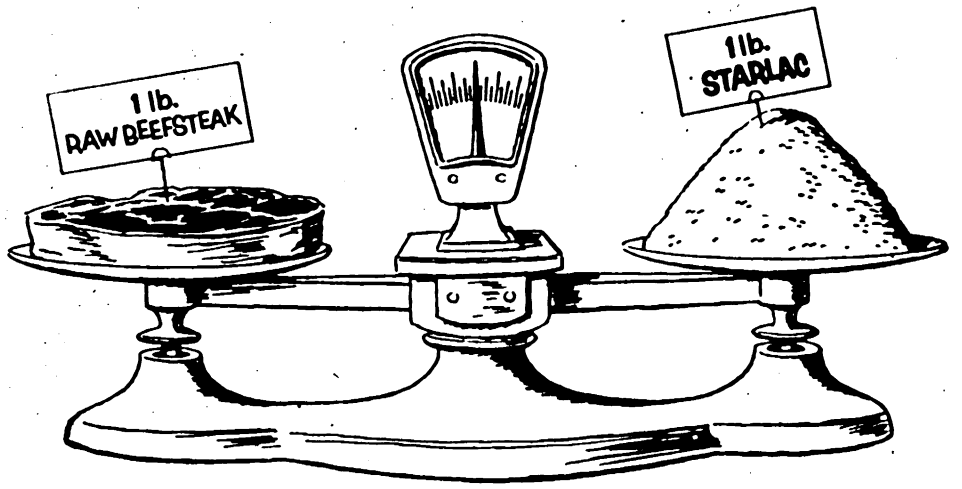
Brought up on a farm, Miss Gorman had to work hard to support herself during her earlier years. After completing Grade XI she took a job as a domestic and also worked in a laundry while she prepared herself for something better. She has held her present position for six years. She enjoys her work in the mail order department very much and has had no difficulties with her co-workers or superiors. Describing her work as "quite responsible," since she is "the worrying kind" Miss Gorman often became quite tense and nervous if the figures did not add up correctly.

On the surface she appeared to be a very quiet, unemotional person who approached the prospect of an operation with a grim determination to "get it over with." On closer acquaintance she revealed a fine sense of humor and a better than average intelligence. Though she worried about her slow recovery and convalescence she was very cooperative and unselfish. She was assured of her job when she was well enough to return to work and an employees' welfare plan helped her financially throughout her illness.

PRE-OPERATIVE CARE

After admission to the hospital conservative treatment was instituted. Miss Gorman was put on a strict convalescent sippy diet later supplemented

Miss Nordwich is a recent graduate of the Misericordia General Hospital, Winnipeg.



Problem: Which contains the most protein?

Answer: 1 lb. of Borden's Starlac contains almost *double* the protein of 1 lb. of edible beef! Yet Starlac costs under 40¢ a pound.

The high protein content and relatively low cost of Borden's Starlac make it valuable in cases where a high protein diet is prescribed.

What is Starlac? Starlac is dry skim milk —a creamy white powder made by removing most of the water (97.5%) and fat (99%) from high quality, fresh whole milk. It takes about 11 pounds of fluid skim milk to make one pound of Starlac. Starlac thus contains about 11 times the food value of liquid skim milk, (except thiamine and vitamin C, slightly reduced during processing.)

Easily and quickly reliquefied, a one pound tin of Borden's Starlac makes 4 quarts of delicious milk. It also combines well with other ingredients—makes possible recipes containing large amounts of protein with only slight increases in bulk in the end product.

You can safely recommend Borden's Starlac wherever a high protein diet has been prescribed. If you would care to learn more about this "wonder milk", just send a postcard with your name and address to The Borden Company, Formula Foods Dept., Spadina Cresc., Toronto and our booklet "STARLAC IN HIGH PROTEIN DIETS" will be sent you.

Borden's
STARLAC

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by a bland ulcer diet of 2,200 calories. Additional vitamins were given orally in capsules and as injections. Amphojel after each meal helped to reduce pain after the nauseating effect was overcome. This treatment continued until April 3, when the doctor decided to operate. By that time vomiting had ceased completely, pain was reduced greatly and the patient had gained considerable strength. Two evenings before the operation her stomach was lavaged and on the morning of surgery a Levin tube established.

Laboratory findings: WBC 5,050 normal — RBC 5,160,000 normal — Hb. 80%. Urinalysis: Negative except for phosphate crystals. Gastric analysis: Fasting total acidity 3, after test meal 35. Free HCl fasting 0, after meal present, otherwise negative. Stool for occult blood, negative.

X-ray report: Chest negative. Stomach normal. Duodenal cap grossly deformed with very small ulcer crater close to base, approx. 1 mm. in diameter. Summary: Duodenal ulcer without retention.

Post-operative Care

On April 4 a gastroenterostomy and vagotomy were performed. On return from the operating room gastric suction and intravenous were working. No oral nourishment was taken for the following four days. On April 8, the suction was clamped off for six hours after which time the stomach was aspirated and 800 cc. of greenish content obtained. Miss Gorman had a bland diet dinner that day. Suction was re-established and continued till April 25, being clamped off in changing intervals according to her tolerance. Nourishment was supplied chiefly by intravenous therapy and whole blood amounting to 4,000 cc. daily. The intake and output were well balanced.

Beginning April 14, small meals were introduced such as junkets, milk, baked potatoes, soft cooked rice, melba toast, poached eggs, custards. The main concern was that the stomach did not empty properly through the new opening. The surgeon called a colleague in consultation. His report reads:

This patient is now 19 days post-operative. No passage of food or gastric secretion into jejunum — perhaps some flatus last evening while up. Patient is in fairly good condition in spite of this but biochemistry probably affected by some dehydration. X-ray does not show any actual mass in stomach (intussusception). I would favor having patient sit up a bit, give her soft solids and prescribe sodium luminal gr. 1 by hypo. If her condition does not improve, surgery might have to be repeated.

Laboratory findings: Serum protein: total protein 8.25 g/100 cc.; globulin 3.8 g/100 cc.; albumin 4.45 g/100 cc.; sodium and potassium S — 148.8 m. Eq/1. P.3.07 m. Eq/1. CO_2 combining power 68 vol. % (Normal — 50-75 vol.%); serum chloride 595 mg.% (Normal — 585-620 mg.%); hb. 125%.

Barium meal — stomach dilated and at onset of the examination, even on second day, there is gross retention. At no time was any barium forced through the stoma of the gastroenterostomy. All the flow through pylorus and there is demonstrated marked dilatation of the third portion of the duodenum and to a lesser degree some dilatation of the second portion. Gross cap deformity exists without any apparent crater visible. Reverse peristalsis in duodenum was noted.

Nursing Care

Environment: It is a well known fact that many patients with acute, proved ulcer symptoms derive complete temporary relief from termination of all connections with environmental anxiety-producing factors, unfavorable diet and poor hygienic conditions. Perfect conditions are rarely obtained, particularly those connected with internal emotional problems. The nurses' success will depend on teaching the patient to realize the importance of and adherence to a regular, sound diet routine, good hygienic habits, necessity for relaxation as well as the avoidance of fatigue and worry.

General nursing care: To promote the full therapeutic effect, Miss Gorman was put on complete bed rest and sedated comfortably. Particular attention was given to skin care since she was expected to lie quietly. Later oc-

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cupational therapy was introduced.

Psychological approach: The often agonizing ulcer pain, and the monotony of a bland diet tended to discourage Miss Gorman before her operation. The nurse had to watch for signs of it, since the patient gave little evidence of her feelings. However, it was obvious that reassurance and a chance to talk things over freely with the nurse were greatly appreciated. The somewhat delayed recovery after the operation added to the strain. Miraculously, when her mental resistance had reached a low point the turning point came. The new opening in the stomach began to work, thus avoiding another operation. This in itself was the best medicine that could have been provided.

Personal care: Before the operation the most important factor was to follow rigorously and punctiliously the diet and medication schedule day and night, to keep the patient free of pain by observing symptoms and time of pain, and adjusting the antacid therapy. After the operation a constant watch on the gastric suction and administration of intravenous fluids were necessary. A very accurate intake and output record had to be kept. Also, any passage of feces through the bowel was of importance as it indicated the success or failure of the operation.

Medications and diet: 40 mg. of pot. chloride and one ampoule of Folbesyn daily into 1 Vs. Demerol 100 mg. for pain as required; Uricholine one ampoule subcutaneously as ordered; Sodium luminal gr. 1 per hypo. b.i.d.; five bottles of whole blood between April 4 and 25; 3,000 cc. glucose daily.

Results

It remains to be seen whether the operation was a complete success. The indications are favorable. A supportive dietary treatment will have to be continued at home for some time. Through health teaching Miss Gorman came to realize that her eating habits and choice of food called for improvement and is very willing to revise them. The prognosis is good if definite care will be exercised; otherwise the ulcers are almost certain to recur.

No social or occupational readjustment was necessary. Since Miss Gorman is an intelligent, very cooperative and willing woman, the dietary problems should be easily solved. The patient realized that any recurrence of symptoms should be reported immediately to her doctor as early treatment assures best results.

A study of this case from all angles of nursing and medicine has taught me a great deal about the close interlocking relationship of the anatomical and mental physiology in the human being, and its importance in adjusting nursing care and treatment. The Roman said: "In a healthy body lives a healthy soul."

Book Reviews

Storming the Citadel — the Rise of the Woman Doctor, by E. Moberly Bell, 200 pages. Longmans, Green & Co., 215 Victoria St., Toronto 1. 1953. Price $3.75.

Reviewed by Matilda R. Diederichs, Providence Hospital, Moose Jaw, Sask.

This book was written at the suggestion of the Dean and Governors of the Royal Free Hospital, School of Medicine, London, England. It is an account of the struggle for recognition of women in the medical profession. The book is authoritative since the author gives reliable sources from both official records and unpublished material.

The status of women in the Victorian Age is surveyed and the story of their gradual emergence, through their own efforts, from the home into the fields of education, journalism, and employment, is briefly told. Then the author contrasts the characters of three outstanding women — all famous pioneers in the era of the rise of the woman doctor. A description is given of the attempts, with all their disappointments, made by these women to be admitted to a medical school, to receive clinical instruction, and to be placed on the Medical Registry.

In the closing chapters, the author consolidates the gains made in the latter years of the 19th century. She relates the opportunities offered to medical women by the outbreak of World War I and how, in the post-war period, they filled the gap resulting from war casualties. The federation of the various associations for medical women and its acceptance by the British Medical Association closes the account.

In this book the author has succeeded not only in writing a fascinating story but also in assembling a mass of facts helpful to anyone wishing to trace the rise of the modern woman and her entry into fields outside the home.

Scientific Terminology, by John N. Hough. 231 pages. Rinehart & Co. Inc., 232 Madison Ave., New York City 16. 1953. Price $3.50.

Reviewed by Adelaide Haggart, Director, Nursing Education, Royal Victoria Hospital, Montreal.

This book has been written primarily for those who are teaching scientific terminology or for students who are studying such a course. The book progresses from simple material to more complex. As a reference, it will be helpful to those who can recall considerable Latin. For those who have forgotten much or all of their Latin studying it would mean considerable work. The index will be of particular value to those who use it for reference purposes.

Considering this book from the point of view of its usefulness in nursing, I realize that there is no time for such a course. However, it would be most beneficial for teachers to have a good background of such material so that they can make terms more meaningful to their students. Relatively few terms are taught or required in anatomy and pathology or pharmacology. Principles are taught in microbiology rather than lists of names of organisms. Everyone who studies chemistry has to become familiar with chemical nomenclature which has been standardized within recent years.

Far too few people have a sound appreciation of the English language and its origin from Greek and Latin as well as the influence of French upon it. After reading this book one wonders why the studies of the

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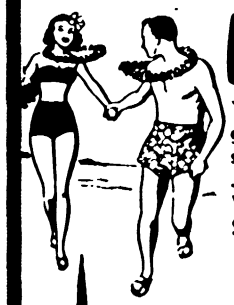

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above languages are not made more vital and useful with respect to our own language. Such a course in scientific terminology would be of great interest to a student who has secured a basic knowledge of Latin or Greek before she delves far in the sciences.

Introduction to Medical Science, by Gulli Lindh Muller, M.D., and Dorothy E. Dawes, R.N., M.A. 609 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 3rd Ed. 1953. Price $4.75.

Reviewed by Olive Wilson, Clinical Instructor in Medicine, Royal Jubilee Hospital, Victoria, B.C.

The authors have accomplished their aim, in this third edition, of bringing us up to date on the rapid advancement of medical science. The book provides a good basic background, covering causes of disease, methods of diagnosis, treatment, preventive measures and control. The newer methods have been carefully incorporated discarding outmoded practices.

A new section has been added on Geriatrics, which is becoming more important today with the lengthening of the life span. In the chapter, Examination of the Patient, a complete case history has been added. This will give the student a better insight into the correlation of the hospital team.

The organization of the health programs — federal, regional, community, industry, home, and the individual — have been discussed in a clear, concise manner showing their interdependence. The control and prevention of disease have been dealt with in relationship to the World Health program.

The section on antibiotics has been entirely revised, new ones added, keeping us abreast of the rapid advancement of this field.

The style of the book is clear and to the point. It would be an asset to the library of any school of nursing for both the instructor and students.

A Handbook for Nursery Nurses, by A. B. Meering, S.R.N. 555 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1953. Price $4.00.

Reviewed by Mrs. Christine Senger, Head Nurse, Kootenay Lake General Hospital, Nelson, B.C.

This is a book worthy of careful study by both nurses and mothers. The author has successfully covered the major aspects of normal healthy child development along with

the diseases that are more prominent in childhood. She not only covers the specific methods of treatment but enlarges on the dietary and mental outlooks of both the well and the invalid child.

Miss Meering has written with clarity and interest. The simplicity of the information would be of great benefit to the average mother and I would recommend it as a most comprehensive reference for the different phases of growth and development.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — Rouyn-Noranda: *Mrs. Mary Côté* (Sacré-Coeur, Hull, Que.). Saskatoon: *Mary Ann Petrone* (St. Joseph's Gen. Hosp., Port Arthur). Winnipeg: *Anastasia Sokulski* (Winnipeg Gen. Hosp.).

Transfer — *Thérèse Gaudette* from Lachine to Pointe Claire, Que.

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Institute on Nursing Education

THE CANADIAN CONFERENCE of Catholic Schools of Nursing held an institute in Montreal when facilities were provided by the new Maisonneuve Hospital school of nursing. The program was led by Rev. Henri Légaré, O.M.I., executive director of the Catholic Hospital Council of Canada, and Sister Denise Lefebvre, s.g.m., chairman of the Canadian Conference of Catholic Schools of Nursing. More than 150 Sisters attended

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from nine provinces of Canada, with representation from 71 schools of nursing.

The aim of the institute was to provide an opportunity for the delegates from the various localities to study the present trends in nursing education which affect Catholic schools of nursing throughout the country. General sessions were held each morning and in the afternoons small work groups discussed various aspects of the general problem. Much was gained from this exchange of ideas and experience, largely because everyone had an opportunity to participate in the discussion.

The general topic — the Catholic school of nursing — was viewed from three aspects: systems of education, teaching staff, and student nurses; its relations with other organizations, chiefly the hospital and the various professional organizations; and finally with reference to the future of nursing education.

The greatest amount of study was allotted to the school itself. The religious and moral education of the student nurses was stressed and the obligation of the school to provide opportunity for development of the student as a whole person. Nursing education that is based on Christian philosophy recognizes the spiritual, intellectual, emotional, physical, and social needs of the student. A lengthy and detailed paper on the organization and content of a course in medical ethics provided a basis for considerable discussion.

The preparation and availability of teaching personnel is a general problem. Though no definite solution was offered, many suggestions were made. The most useful way to meet this need seemed to be by making scholarships available to interested and suitable nurses, with a definite commitment to return to the school providing the funds for a period of time as an instructor.

"The Psychology of Human Relations" by M.L.T. Dayhaw, Ph.D., professor at the University of Ottawa, reviewed the important points that contribute to good morale. Some of the highlights included discussion of incentives to work, consideration of individual differences, and the need of each individual to be aware of the organizational pattern and relationships of all within the organization.

Among the various systems of nursing education that were discussed were: the two-year program, the block system, centralized schools, centralized teaching programs, and teaching of auxiliary workers. Miss Margaret Foley, M.Sc., nursing education secretary of the Catholic Hospital Association of the United States and Canada, gave a clear and concise description of central schools, their advantages and disadvantages, and the difference between these and a centralized teaching program. She stressed that centralization is a means towards the improvement of educational programs by the pooling of resources. It is not a cure-all but a technique that is useful in some situations, undesirable in others.

A forum on the social formation of the student nurse occupied one evening session. Many of the Sisters described their programs for social activities. It was generally agreed that a committee of students, with faculty advice, can plan and inaugurate a satisfactory program according to the locality and facilities available. Its necessity in the life of a student nurse is quite obvious.

School-hospital relationships were discussed from the point of autonomy of the school, financial status — including an independent budget — and relationships of nursing education and nursing service. Patterns of organization were discussed in regard to the latter but no agreement was reached as to which is preferable.

The discussion on professional relationships pointed out the necessity of all nursing Sisters actively participating in their national, provincial, and local professional nursing organizations. Student nurses' associations were briefly commented upon. Teamwork and non-professional personnel also occupied an important place in the matter of professional relationships.

The work of international organizations to relieve poverty, illiteracy, and misery was ably presented by André Renaud, O.M.I., who worked with UNESCO. He pointed out that through the Economic and Social Council, a non-political body, specialized agencies have been set up to assist millions towards higher standards of living and culture. The influence of the Christian nurse through WHO cannot be overestimated.

Nursing education of the future is of concern to all. There are many trends and many experiments in different directions. It is necessary for all schools of nursing to keep abreast of the times in order to meet the changing patterns of medical care by an adequate preparation of the nurse of tomorrow.

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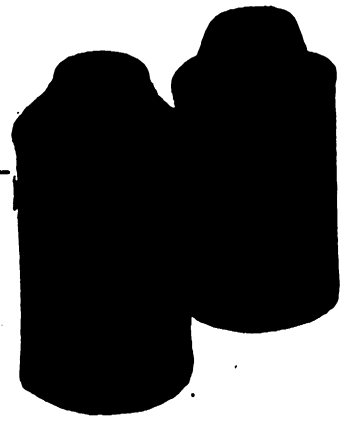

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News Notes

ALBERTA
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CALGARY

Holy Cross Hospital

The annual School of Nursing Day was held in May and more than 150 students registered from Calgary high schools, as well as from many other smaller centres. Several teachers were present. The student nurses conducted tours of classrooms, laboratories, demonstration rooms, nurses' residence, several wards, and special services. Sisters and instructors served refreshments.

BRITISH COLUMBIA

LANGLEY PRAIRIE

Bursary students L. Sater and R. Marron were guests of honor at the annual dinner meeting of South Fraser Chapter. A welcome was extended by Mrs. F. D. Sinclair. The guest speaker was Alice Wright, R.N.A.B.C. registrar, who showed colored slides taken during the I.C.N. Congress in Brazil.

PRINCE GEORGE

At a dinner meeting of Fort George Chapter recently, A. L. Wright, R.N.A.B.C. registrar of nurses, told of her experiences as provincial delegate to the I.C.N. in Brazil and her subsequent visits to some other countries. Her emphasis on the importance of work done at the Congress and her description of the lighter aspects of her travels combined to make an extremely interesting address.

TRAIL

At a recent regular meeting of the chapter, a motion donating up to $50 (subject to the final decision of the executive) to the district delegate to the C.N.A. Biennial Convention in Banff was made. Mrs. J. Mayers is now social convener. Miss Eidt reported that all available help would be needed to transfer patients and set up the new hospital. All nurses in Trail were requested to leave their names at the hospital so that they might be reached when needed.

VANCOUVER

St. Paul's Hospital

At the recent graduation exercises of the school of nursing the following participated: Invocation, Rev. F. W. Hill; opening address, His Worship, Mayor F. Hume; vocal selections, the school choir conducted by M. Fewster; address to the class, The Hon. E. Martin, Minister of Health and Acting Premier of B.C.; presentation of diplomas, Rev. P. Monahan who also congratulated

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the graduates and Mr. A. H. J. Swencisky; presentation of medals, Srs. M. Celina and Denise Marguerite, G. Wahl, E. Black; award winners, B. Moody, E. Quenville; valedictory, S. Twentyman.

MANITOBA

BRANDON

The first venture of the Association of Graduate Nurses in providing a program to benefit the entire membership was launched when delegates from Brandon, Souris, and Hartney attended the opening sessions recently of the nurses' institute. For the two days scheduled, the discussion — "Ward Supervision, Administration and Teaching" — was directed by Hazel Keeler, director of the University of Saskatchewan School of Nursing, Saskatoon. E. M. Cranna, chairman of the educational committee, introduced Miss Keeler and outlined the work completed since the first scholarship was given in 1942, noting that of nine nurses who received additional post-graduate education eight had returned to Brandon. Addresses of welcome were given by Dr. J. R. C. Evans, president of Brandon College; A. K. McTaggart, administrator of Brandon General Hospital and president of the Manitoba Associated Hospitals; and Dr. A. H. Povah, medical superintendent, Brandon Hospital for Mental Diseases. The president, Mrs. M. C. Hannah, conducted the first afternoon session and the institute concluded with a banquet at Brandon Sanatorium.

Annual reports at a meeting of the association, chaired by Mrs. Hannah, revealed definite progress and accomplishment. E. Cranna reported the nursing institute a success with 89 nurses attending. Red Cross first aid lectures were planned. M. Gemmell, one of the first presidents, gave an interesting résumé of the early days of the association, recalling the flu epidemic of 1918, of cases far removed from the city, and her attendance with C. Macleod in 1918 at the convention in Vancouver when Jean Gunn was the speaker. Miss Gemmell nursed in the U.S. in 1914 and was a city nurse in Brandon and with the Bigelow Clinic before joining Dr. McDiarmid's staff.

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in the fall: President, Mrs. G. Brereton; vice-presidents, Mmes H. Harris, W. Dechka; secretary, Mrs. R. McCallum; treasurer, Mrs. F. Durnin; social convener, L. Millions.

Among the nearly 100 guests attending the annual dinner of the Association of Graduate Nurses were 34 new graduates from the Hospital for Mental Diseases and the General Hospital. The president, Mrs. Hannah, presided and the following participated in the program: Mrs. A. Lewis proposed the toast to the graduating classes and J. McDonald responded; Mrs. D. Johnson voiced a vote of thanks to the retiring officers; Mrs. A. Harris introduced and L. Millions thanked the guest speaker, Mr. C. Bjarnason of Brandon Collegiate, whose theme, "People Run Upstairs to Run Down People," dealt with the results, such as heart diseases and heartache, of the speed in the living of today.

General Hospital

At the recent graduation exercises of the School of Nursing, 23 nurses were presented with diplomas by H. McCullough and pins by M. E. Jackson. W. Fotheringham welcomed the guests and introduced Rev. J. Patrick who addressed the class. Others participating were: J. Woodmass, valedictory address; Dr. R. Myers, presentation of medals and prizes; Mr. McCullough, scholarships and bursaries. Those winning awards were: J. McDonald, J. Douglas, J. Allen, E. Templeton, M. Chalmers, F. Reeve, G. Collier, M. Spratt, G. Harder, L. McClement, O. Nawalkowski. E. Hinks won *The Canadian Nurse* Award. Bursaries went to F. Fordyce and F. Larson.

WINNIPEG

General Hospital

The alumnae association held its annual dinner in honor of the 1954 graduating class when there was a good attendance with a very fine program. An interesting feature was a roll call of each year since the inception of the school of nursing. The guest speaker was Dr. A. R. Huband, minister of Westminster Church. The 1929 class celebrated their 25th anniversary with a representation of 27 nurses.

Misericordia General Hospital

At the commencement exercises recently, Msgr. I. E. Zielonka, assisted by Dr. A. R. Gordon, presented diplomas to 22 nurses and Dr. E. R. Gubbay addressed them briefly. Sr. St. Odilon, director of the nursing school, administered the Florence Nightingale Pledge while Mrs. G. Evoy, hospital auxiliary president, handed the special awards to the following: Srs. Arthur Marie and Marie de la Providence, A. Schellenberg, L. Wilvers, and R. Morris. The first award ever given for the best bedside student nurse went to N. Rieger, Class '56, and *The Canadian Nurse* Award to D. Balcaen who also gave the valedictory address.

Victoria Hospital

Rev. G. R. Service extended a welcome to those attending the recent graduation exercises of the school of nursing and Rev. G. F. Dyker addressed the graduating class. There were nine graduates and Mrs. L. Wolfe, superintendent of nurses, presented the diplomas. After the Florence Nightingale Pledge, Wanda Dunn gave the valedictory address and J. Stewart, instructor, directed the presentation of the following awards: C. Badowich, D. Wardrop, S. Burnside. J. Lawler received *The Canadian Nurse* Award.

NEW BRUNSWICK

NEWCASTLE

A good representation of members was evident at the May meeting of Miramichi Chapter and plans for the annual dinner reunion, with Dr. Poser as guest speaker, were discussed. Miss Lynds, administrator of the Miramichi Hospital, reported that it was decided at the N.B.A.R.N. executive meeting to hold the annual provincial meeting in Edmundston on Sept. 22 and 23. Sr. Skidd of Hôtel Dieu Hospital was appointed chapter delegate. New legislation is being sought for licensing all who nurse the sick for hire. The Council is considering the idea of an independent school after relinquishing that of central schools in N.B. They believe the former to be more feasible and generally acceptable. Srs. Skidd and Nowland, and Mrs. Jarvis participated in an interesting panel discussion.

MONCTON

Nurses' Hospital Aid

The president, Mrs. J. Innes, presided at the May meeting when Mrs. S. Sinclair reported on the dinner and dance in honor of the graduating class of Moncton Hospital. Mrs. J. Morrell was named convener for the annual Tag Day and Mrs. Young won the Mystery Box.

NOVA SCOTIA

HALIFAX

Victoria General Hospital

A year of achievement and interest was reviewed at the annual meeting of the alumnae association in May. Projects such as the Red Feather drive, Red Cross, March of Dimes, and Cancer Society benefited by substantial donations and three food parcels were sent to an elderly nurse in England. The student body was assisted as follows: Volumes of *The Canadian Nurse* were bound for their use; $25 was contributed to the Year Book Fund; and $100 to the Students' Council enabling them to send a delegate to the C.N.A. Biennial Convention in Banff; the expenses of a student to the annual meeting of the R.N.A.N.S. in New Glasgow were paid and a prize offered to the one making the highest marks in surgery in the final exams.

Sister alumnae associations of the Nova Scotia and the Children's hospitals were entertained in March. Two speakers during the year were: Dr. H. B. Atlee and Mrs. E. McCara. Mrs. C. Johnstone was appointed delegate to the R.N.A.N.S. annual meeting. Mmes C. Hodgson and D. Foster formed a group to assist the Cancer Society in making dressings while members able to do so volunteered for Civil Defence nursing. A successful Christmas tea and sale were held. The completion of the alumnae room furnishings was a notable part of the year's efforts and this room is now used for executive meetings. Plans to re-establish the War

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PROFESSIONAL ADJUSTMENTS II

Just off the press. For this new edition, the greatest change has been in Unit IV, Organizations. Class exercises and bibliography follow each chapter, as in Volume I. 510 pages, fourth edition, 1954. $5.00.

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Director of Nurses, Toronto Hospital, Weston, Ontario

Memorial Plaque for nurses lost in World War I were discussed.

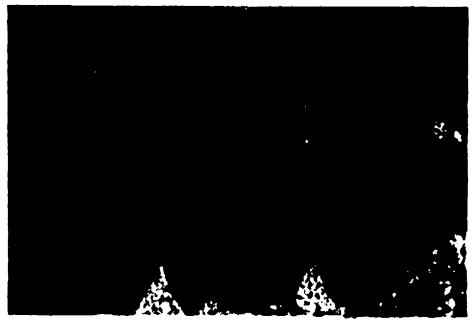
At the close of the business meeting, President Mrs. H. S. T. Williams spoke on the history, achievements, and aims of the association formed in 1920. Serving with Mrs. Williams are: Vice-presidents, S. Nott, G. Flick; secretary, J. Candle; treasurer, Mrs. L. Bell; program convener, E. Haliburton; board of directors, Mmes T. Carpenter, W. Hunt, J. Cameron.

ONTARIO

District 1

Windsor

Once a year the Industrial Nurses' Educational Association of Essex and Kent Counties holds a dinner meeting to which are invited representatives from top management, personnel directors, and industrial physicians and surgeons. A special speaker is obtained for these occasions. On April 20 approximately 90 industrial nurses met at the Elmwood Hotel, Windsor, and included in the group were: presidents, general managers, personnel directors, and doctors from industry. Because of the special interest in the speaker's topic, planning engineers from industry, hospital heads from local and district hospitals, and the president of the Essex County Medical Association were also present. The speaker was Marion Wright, associate director of Harper Hospital, Detroit, Mich. The topic of her address was "The Better Utilization of Hospital Personnel," dealing with the study that she has made in applying industrial management principles to the field of nursing. This has been accomplished by the guidance of outstanding industrial engineers who did the research for the project.



Windsor Daily Star Photo

In the photo may be seen (*left to right*): R. Thompson, director of nurses, Metropolitan General Hospital, Windsor; Mr. O. R. Goodrich, Packard Motor Car Co., Detroit; Marion Wright; Doris E. Pickel, Chrysler Corp. of Canada Ltd., Windsor, and president, I.N.E.A. of Essex and Kent Counties.

District 6

Cobourg

The semi-annual meeting of the district

was held in May with Mrs. F. Leeson, chairman of Chapter B, as hostess. The business meeting followed the banquet and the chairmen of Chapters A, B, and C reported on their group activities. Miss Peart summarized the highlights of the R.N.A.O. convention she had attended and the last Board meeting. The guest speaker was the provincial secretary of public relations, E. Fenton, who gave an excellent talk on "Are We Professional Women?" The next district meeting will be held in the fall in Peterborough.

District 8

Ottawa

General Hospital

Sr. Flavie Domitille, superior of St. Joseph's Hospital, Sudbury, since 1948, was appointed to a similar position at St. Joseph's Hospital, Lowell, Mass., in January. Graduating from O.G.H. in 1913, Sr. Domitille has served the hospital in such capacities as: supervisor of the children's ward and later the operating room, superintendent of nurses from 1922 to 1940; superior till 1943 and finally supervisor of the ward for sick sisters till her departure to Sudbury.

Seventy-five nurses attended the alumnae-sponsored annual memorial service for nurses who died in both World Wars and over 150 nurses were present at the annual communion breakfast when Rev. Morrocco, as guest speaker, chose the subject "Vocation".

Lady Stanley Institute

The annual meeting of the alumnae association was well attended and the following were elected to office: Honorary president, Mrs. W. S. Lyman; honorary vice-presidents, M. Stewart, E. Young; president, Mrs. G. O. Skuce; vice-presidents, Mmes C. Port, H. M. Ellard; secretary, Mrs. R. B. Bryce; treasurer, M. Scott; in various other capacities, C. Pridmore, E. Johnston, D. Booth, Mmes M. Jones, L. Gisborne, J. Steele, E. Aust, W. Fraser, G. Bennett, J. Waddell.

District 12

Kirkland Lake

Prior to a regular business meeting of the chapter, an instructive film on "Teamwork," relating to the R.N. and co-workers in the hospital, was shown. The fashion show convened by Mrs. M. Eady was a complete success. The proceeds, as well as those of the recent rummage sale, will be used for winter projects.

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Royal Victoria Hospital

Rev. G. Cragg was guest speaker at the

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recent graduation exercises for 97 graduates of the school of nursing. Prize winners were: B. Pritchard, A. Hathaway, M. McKillop, M. Monahan, A. Johnston, J. Henderson, T. Pattenden, C. Walkem, and J. Loney who won *The Canadian Nurse* Award. A reception followed the ceremonies. Parents and friends attended a parent and daughter tea in honor of the class. During graduation week those present at the 25th anniversary reunion of Class '29 were: E. (Archibald) Rand, M. (Bowers) Ambrose, L. (Cameron) Smith, M. (Cosgrove) Decarie, C. (Dart) Johnston, E. (Davidson) Ross, M. (Douglas) Pond, J. Dunning, H. (Eberle) Cranston, D. Gibson, G. (Green) Woods, M. (Hamilton) Tremble, H. (Horncastle) Brigg, E. (MacCrimmon) Daly, K. (Martin) Hodgson, A. Peabody, M. (Perley) Pilkney, M. (Steeves) Morrell, J. (Stewart) Sampson, R. (Swan) Clibbon, M. Swartz, E. (Ward) Clark. A tea was held in their honor and 21 of the group attended the annual alumnae dinner.

New officers elected at the annual meeting of the alumnae association are: President, M. Purcell; vice-presidents, H. Lamont, M. Butler; recording secretary, L. Rosevear.

Guest of honor at a tea recently was J. Rainboth who resigned to be married. I. (Macmillan) Applegarth was a recent visitor to the school. C. Hodge is on the staff of Valley Hospital, Ridgewood, N.J., and J. Whittier, the staff of the Children's Hospital, Boston, Mass., the latter planning to later attend Smith College, Northampton, Mass., for further study.

Officers of the new chapter in Fredericton are: President, A. (Barnet) Crewdson; vice-president, D. Loane; secretary, K. (Janier) White. Graduates living in Woodstock, McAdam, and Oromocto are invited to join. Eleven members attended a recent meeting of Sydney Chapter. Fourteen members of London Chapter were present at a tea held by A. (Bigelow) Kennedy in honor of M. (Hannah) Nivens, a graduate of the Class of 1898, on her 92nd birthday. D. (Rice) Storer has resigned as secretary of Moncton Chapter.

SASKATCHEWAN

SASKATOON

Nurses from St. Paul's and City hospitals formed the choir at the annual vesper service of the chapter recently. The topic of Dr. L. Campbell's sermon was "The Glory of the Common Man."

City Hospital

The Alumnae association entertained the graduating class recently and Mrs. A. MacMillan, president, welcomed the guests. Each student received a year's membership in the alumnae with best wishes for the future and a social evening under the convenerships of Mmes D. Parkinson, D. Andres, and J. Levers ensued.

Members of Class '55 gave a banquet in honor of their "big sisters," Class '54, attended by some 120 students. Rev. H. Joyce, guest speaker, was introduced by E. Kearney and thanked by R. Miller. Toasts were proposed by B. Gibson and Mrs. H. Wilson, with J. Brown and N. Badham responding. During the evening D. Morgan gave a recitation and D. Kindrachuk and L. Russell accompanied by B. Smith, musical selections. Guests of honor were: Rev. and Mrs. Joyce, Mr. and Mrs. J. Armstrong, Mr. and Mrs. L. Muirhead, Mrs. Wilson and members of the nursing office staff.

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Matron for 24-bed hospital. Salary: $265 per mo. less $40 board & lodging. 1 mo. holiday with pay after 1 yr. Staff: 4 nurses, 4 aides, x-ray lab. technician. Attractive town. Pleasant climate. Apply Administrator, Terrace & District Hospital, Terrace, B.C.

Director of Nursing for new 87-bed hospital for Chronically Ill which is combined with new 165-bed Home for the Aged. Salary according to qualifications & experience. Apply Mr. M. Rosenberg, Administrator, Jewish Home for the Aged, 3560 Bathurst St., Toronto 12, Ontario.

Asst. Supervisor for Obstetrical Dept. Obstetrical or university post-graduate course preferred, with adequate experience. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

Nursing Arts Instructor for School of Nursing — approx. 60 students. New hospital in Central Western Ontario. 1 yr. university in teaching essential. Living accommodation in newly decorated residence. Good personnel policies. Apply Director of Nursing, General Hospital, Stratford, Ont.

Nursing Arts & Nursing Science Instructor. Also **Graduate General Staff Nurses.** New 172-bed General Hospital. 44-hr. wk. Good personnel policies & working conditions. Apply Director of Nursing, South Waterloo Memorial Hospital, Inc., Galt, Ont.

Instructor — capable of teaching **Psychiatric Nursing** to affiliating students. Good salary. Living accommodation available. Apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ontario.

General Duty Nurses for 650-bed Teaching Hospital in Central California. Salary: $273-320 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel office, 510 E. Market, Stockton, California.

General Duty Nurses. Those registered start at $160 per mo. plus full maintenance. Annual increment — $5.00 per mo. for each of 3 yrs. 4 wks. vacation. (Graduate Nurses start at $150 plus full maintenance.) Apply Supt., Alexandra Marine & General Hospital, Goderich, Ont.

General Duty Nurses (2) — one each for July 1 & Aug. 1. Salary: $180 per mo. plus full maintenance. 3 increases of $5.00 per mo. for each yr. experience to a maximum of $195. 3 wks. holiday with pay plus all statutory holidays. Separate nurses' residence. Apply Matron, Municipal Hospital, Fairview, Alta.

Graduate General Duty Nurses for Children's Orthopedic Rehabilitation Centre, 24 miles from New York City. 5-day, 40-hr. wk. Liberal personnel policies. Modern staff residence. Write, stating qualifications, Director of Personnel, Blythedale, Valhalla, New York.

Nurse for Catholic Children's Aid Society — public health or children's hospital experience preferred. Salary commensurate with training & experience. Duties include following progress & development of infants in foster homes & institutions. Contributory retirement & medical plans. For details, write Miss I. Allen, Director, Catholic Children's Aid Society, 67 Bond St., Toronto 2, Ont.

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200-bed hospital — 65 students. One class per year enters in September. Allowance made for degree with experience.

For further information apply:
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Supt. of Nurses & General Duty Nurse (1). Salaries: Supt. — Open; Gen. Duty — $170-190 plus full maintenance; also half M.H.S.A. & M.M.S. New 56-bed hospital with separate residence — private suite for Supt. Apply Mrs. L. W. Borthwick, Sec.-Treas., District General Hospital, Morden, Man.

Supt. of Nurses & O.R. Supervisor for General Hospital, Dauphin, Man. 86-bed hospital with Nurses' Training School. Community of 6,500. Excellent living conditions. Supt. of Nurses must be good organizer & disciplinarian. Salary open for both positions. For further information apply A. J. Schmiedl, Sec.-Mgr.

Supt. of Nurses for modern 60-bed General Hospital. Apply, stating qualifications, Dr. M. R. Stalker, Honorary Medical Supt., Barrie Memorial Hospital, Ormstown, Que.

Asst. Supt. with X-Ray experience or willing to learn X-Ray technique preferred. Apply Dr. W. A. Oakes, Public Hospital, Clinton, Ont.

Director of Nursing Education; Nursing Arts Instructor; Operating Room Supervisor. Nursing School — 65 students — with 1 class per yr. Good personnel policies & facilities. Full maintenance in residence if desired. Apply B. A. Beattie, Director of Nursing, Public General Hospital, Chatham, Ontario.

Instructor in Science & Surgical Nursing for new school taking in one class yearly. Responsible for teaching Chemistry, & Anatomy & Physiology in 1st term & the Surgical portion of an integrated course in Medical-Surgical Nursing in 2nd term. Splendid opportunity to help develop new school being established on sound educational lines. For further information apply Director, School of Nursing, Metropolitan General Hospital, Windsor, Ont.

Instructors for: Science Teaching followed by Clinical Ward Teaching; Clinical Ward Teaching & lectures in Medical Nursing. Commencing salary: $250 (additional for experience). Current R.N.A.B.C. contract in effect. 65 students; one class per yr. For information about position & community apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Instructor in Nursing Arts. Clinical Instructor in Medicine. Clinical Instructor in Surgery. For School of Nursing by Aug. 1. 177-bed hospital; affiliation arranged in Tuberculosis & Psychiatric Nursing. Maximum of 60 students. One class per yr. Complete maintenance available. Excellent personnel policies. For further particulars apply Miss E. A. Bietsch, Director of Nursing, General Hospital, Medicine Hat, Alberta.

Science Instructor for June or Sept. Complete maintenance in comfortable suite. 120-bed hospital — 35 students. New 150-bed hospital under construction. Apply, stating experience & salary expected, Director of Nurses, Jeffery Hale's Hospital, Quebec City, Quebec.

Clinical Instructor (Nursing Arts). Modern 400-bed hospital. Student body — 100. Salary commensurate with position. Good personnel policies. Apply Director of Nursing, Kitchener-Waterloo Hospital, Kitchener, Ont.

VANCOUVER GENERAL HOSPITAL

The Vancouver General Hospital requires:

General Staff Nurses. 40-hr. week. Salary of $231.00 as minimum and $268.50 as maximum, plus shift differential for evening and night duty.

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Residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

Science Instructor (1) & Nursing Arts Instructor (1) for Sept. School with approx. 90-100 students. Apply Director of Nurses, Victoria Public Hospital, Fredericton, N.B.

Nursing Arts Instructor for School of Nursing. 150 students—450-bed hospital. Apply Director of Nursing, General Hospital, Saint John, N.B.

Clinical Supervisors & Instructors: Surgical (2) & Medical (2). Also **General Staff Nurses.** Personnel policies based on R.N.A.O. recommendations. For full details apply Director of Nursing, General Hospital, Port Arthur, Ont.

Public Health Nursing Supervisor & Public Health Nurses for generalized public health program. Attractive salary & working conditions. Blue Cross, Workmen's Compensation & other benefits. For information or application forms apply Mr. J. R. Coleman, Sec.-Treas., Simcoe County Board of Health, Court House, Barrie, Ont.

General Supervisors, Charge Nurses & General Duty Nurses for new 150-bed hospital. Starting salary for General Duty Nurses — $220 for B.C. Registered, with annual increases up to $30. 40-hr. wk. 1½ days cumulative sick leave. 28 days vacation. 11 statutory holidays. Apply Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

Supervisor for 327-bed Tuberculosis Sanatorium **& General Duty Nurses for Surgical Unit handling Thoracic & Orthopedic Surgery.** For further information apply Director of Nursing, Fort William Sanatorium, Fort William, Ont.

Evening Supervisor & General Duty Nurses for General Hospital. 88 adult beds plus 30 bassinets. For particulars apply Director of Nursing, Norfolk General Hospital, Simcoe, Ont.

Public Health Nurse — Grade 1 — British Columbia Civil Service, Dept. of Health & Welfare. Starting salary: $255-260-266 per mo. depending on experience, rising to $298. Promotional opportunities available. Candidate must be eligible for registration in B.C. & have completed University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects under 40, except in case of ex-service women who are given preference. Further information may be obtained from Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C. Application forms obtainable from all Govt. agencies, Civil Service Commission, Weiler Bldg., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Victoria, B.C.

Public Health Nurse for Health Unit for generalized program. Proximity to Toronto permits urban living conditions to be combined with rural-urban work. Excellent transportation arrangements, group insurance & other attractive working conditions. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

Nurse Technician Team (intravenous & intramuscular therapy). Apply Dr. H. Featherston, Asst. Supt., Civic Hospital, Ottawa, Ontario.

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Good salary and personnel policy.

For further information apply to:

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Public Health Nurses (bilingual) for Prescott & Russell Health Unit. Minimum salary: $2,600 with allowance for previous experience & annual increments. Car provided or allowance for own car. Blue Cross & sick leave. Apply Dr. R. G. Grenon, Director, Prescott & Russell Health Unit, Hawkesbury, Ont.

Public Health Nurses for Dept. of Health, City of Kingston. Salary range in effect. Transportation provided. 5-day wk. Pension & hospitalization plans available. Apply Medical Officer of Health, City Hall, Kingston, Ont.

Public Health Nurses (qualified & experienced). Salary schedule: $2,500-3,100 depending on experience. Annual increment, $100. Pension plan. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Public Health Nurse for generalized program in Alberta East Central Health Unit (Stettler office). Minimum salary: $2,520. Experience recognized up to 3 yrs. Annual increments. Pension plan; Blue Cross. For details apply Dr. D. MacKay, Medical Officer of Health, Stettler, Alta.

Registered Nurse for General Duty for 8-bed hospital immediately. Salary, holidays & sick leave according to M.A.R.N. Must be able to speak both French & English — preferably R.C. Those interested apply Sr. Marie Jean, Superior, Notre-Dame de Lourdes, Manitoba.

Registered Nurses (2) for General Duty. 40-bed Municipal Hospital. Starting salary: $180 per mo. plus full maintenance to maximum $220 according to nursing experience. $5.00 per wk. extra for night duty. 44-hr. wk. 3 wks. holiday with full pay after 1 yr. service. Statutory holidays. Modern nurses' home on grounds. Apply Sec., Municipal Hospital, Box 560, Taber, Alta.

Registered Nurses for General Duty Staff. Salary commences at £37-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for new 30-bed hospital. R.N.A.B.C. policies in effect. Apply Matron Creston Valley Hospital, Creston, B.C.

Registered & Graduate Nurses for General Duty for 100-bed hospital. Apply, giving experience, references, etc., Supt., The Cottage Hospital, Pembroke, Ont.

Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience, Matron, Terrace & District Hospital Terrace, British Columbia.

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Graduate Nurses (3) at once owing to present nursing staff leaving to get married. 30-bed hospital on C.P.R. main line & Trans-Canada Highway, 2 hrs. from Calgary. Modern nurses' residence & garage. 8-hr. day, 6-day wk. with rotating shifts. Starting salary: $170. $5.00 increase at end of each 6 mos. 3 wks. holiday & statutory holidays. Sick leave with pay & free hospitalization. Apply Matron, Municipal Hospital, Bassano, Alberta.

Graduate Nurse (qualified) to conduct Certified Nursing Assistant Course & Staff Education in 100-bed hospital. Apply, stating qualifications & experience, Director of Nursing, Norfolk General Hospital, Simcoe, Ont.

Graduate Nurses for General Duty. Living-in accommodation if desired. Apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

General Duty Nurses. Gross salary: $200 per mo. with 1 yr. or more of experience; $190 per mo. with less than 1 yr. experience; $20 per mo. bonus for evening or night duty. Annual increment, $10 per mo. 44-hr. wk. 8 statutory holidays. 21 days vacation & 14 days sick leave with pay after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

General Duty Nurses. Salary: $182.43 (one hundred eighty-two dollars & forty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

General Duty Nurses — "You will like it here." Placement in the service of your choice in Teaching Hospital. Beginning salary: $240 per mo. for 40-hr. wk. Scheduled increases, payment for overtime, 6-hr. evening duty. $270 per mo. for night duty. Sick leave, 6 holidays, 3 wks. vacation. Residence facilities if desired. Tuition-free courses after 6 mos. service. Opportunities for advancement. Apply Director of Nursing Service, University Hospitals of Cleveland, Cleveland 6, Ohio.

General Duty Nurses for 920-bed General Hospital. Starting salary: $190-210 per mo. plus meals & laundry. Credit for past experience, annual increments. 44-hr. wk., rotating shifts. Statutory holidays, 21 days vacation, cumulative sick leave, hospitalization subsidized, pension plan. For further information apply Supt. of Nursing Service, University of Alberta Hospital, Edmonton, Alta.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved Student affiliation & post-graduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

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Westminster, London	Shaughnessy, Vancouver

Application forms, available at your nearest Civil Service Commission Office, National Employment Office or Post Office, should be filed with The Civil Service Commission, Ottawa.

CIVIL SERVICE OF CANADA

General Duty Nurses for United Church of Canada hospital, 300 miles north of Vancouver on B.C. coast. Salary: $215 per mo. less $40 for board, room & laundry of uniforms. 2 annual increments of $5.00 per mo. Cumulative sick time — 1½ days per mo. 1 mo. annual holiday plus 10 days in lieu of statutory holidays. Transportation refunded after 1 yr. Apply Matron, R.W. Large Memorial Hospital, Campbell Island P.O., Bella Bella, B.C.

General Duty Staff Nurses for 515-bed General Hospital. 40-hr. wk. Beginning salary: $260 per mo. with advancement to $285; $20 additional for evenings & nights. Hospital & School of Nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

General Duty Registered Nurses for large city hospital. Vacancies in Medical, Surgical & Pediatric Wards. Salary: $50-56 per wk. 44-hr. wk. Vacation, 3 wks. Illness allowance, 18 days per yr. after 1 yr. service. Apply Director of Nursing, General Hospital, Hamilton; Ont.

Operating Room Nurse (experienced, preferably with post-graduate course). **Operating Room Staff Nurses.** Opportunity for advancement. Full maintenance. Travel allowance. State qualifications & date available. For full particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

General Duty Nurses for new 100-bed hospital. Basic salary: $170 plus maintenance. 3 wks. vacation. 8 statutory holidays. Rotating shifts. Apply, with full particulars, Supt., Lord Dufferin Hospital, Orangeville, Ont.

General Duty Staff Nurses for 175-bed hospital, located 20 miles from Detroit. Excellent personnel policies with opportunities for advancement. Apply Director of Nursing, St. Joseph Hospital, Mount Clemens, Michigan.

General Duty Nurses for Obstetrical, Surgical & Pediatric Wards. 375-bed hospital with Training School. Residence accommodation if desired. Progressive city on main line to Toronto & Montreal. Apply Director of Nursing, General Hospital, Brantford, Ont.

General Duty Nurses for 430-bed hospital. Salary: $230-260. Credit for past experience. Annual increments. 40-hr. wk. Statutory holidays; 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

General Duty Nurses for Medical & Surgical Wards. Personnel policies based on R.N.A.O. recommendations. $50 towards transportation refunded after 1 yr. service. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

Clinical Instructors for Obstetrical & Medical Depts. (qualified). Also **General Duty Nurses** for 500-bed hospital. Attractive personnel policies. Apply Director of Nurses, St. Joseph's Hospital, Victoria, B.C.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

WOODSTOCK GENERAL HOSPITAL
WOODSTOCK, ONTARIO

Operating Room Nurse (General Duty)

Apply, stating qualifications, to:

DIRECTOR OF NURSES, GENERAL HOSPITAL,
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Nurses (2) for 20-bed hospital. Modern nurses' residence. Salary: $190 per mo. plus full maintenance. Usual holidays with pay, sick leave, etc. Apply Matron, Union Hospital, Vanguard, Sask.

Nursing Arts Instructor for General Hospital, Sarnia, Ont. Post-graduate in Nursing Education from recognized university. 50 students at present & estimated 22 in Sept. preliminary class. New & well equipped hospital & School of Nursing. Minimum gross salary: $250 per mo. Apply Mr. H. K. Krafft, Supt.

Obstetrical Supervisor for 70-bed General Hospital. Salary: $200 per mo. & up, depending on qualifications. Good personnel policies. Apply Supt., Ross Memorial Hospital, Lindsay, Ontario.

Operating Room Head Nurse (experienced) with post-graduate training for 117-bed General Hospital in the Okanagan Valley. Also **Registered Nurses for General Duty.** Basic salary: $225 — credit for experience. 40-hr. wk. Annual increments. 28 days annual vacation. Apply Director of Nursing, Jubilee Hospital, Vernon, B.C.

Matron immediately for 27-bed hospital. Graduate complement: matron & 4. 8-hr. day, 44-hr. wk. 28 days holiday after 1 yr. service. Customary sick leave. Knowledge of x-ray essential. Apply, giving full details & salary expected, Sec., Slocan Community Hospital, New Denver, B.C.

General Duty Graduate Nurses (2). Salary: $220 with annual increments of $5.00 per mo. Full maintenance in hospital — $40 per mo. 28 days holiday after 1 yr. service. Customary sick leave. Apply, with full particulars, Sec., Slocan Community Hospital, New Denver, B.C.

Public Health Nurse immediately for rural program. Minimum salary: $2,600; adjustment made for experience. Statutory holidays & 1 mo. vacation after 1 yr. Write for particulars Dr. J. I. Jeffs, M.O.H., Lennox & Addington County Health Unit, Napanee, Ontario.

General Duty, Operating Room & Obstetrical Nurses. Salary: $200 for recent graduates Laundry. 8-hr. day, 44-hr. wk. — straight shift. $20 differential evenings — $15 nights. Vacation, sick time, statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Director of Nursing, General Hospital, Winnipeg, Man.

General Duty Graduate Nurses for 60-bed Acute General Hospital, 150 miles northwest of Vancouver on B.C. coast. Salary: $222 per mo. with increments; less $25 complete maintenance. 4 wks. holiday per yr. with pay plus 10 statutory holidays. Transportation advanced if desired. Apply Matron, St. George's Hospital, Alert Bay, B.C.

General Duty Nurse for 14-bed hospital. 8-hr. shift (alternating). Salary, vacation, sick leave as set by M.A.R.N. Apply Mrs. Eva Green, Memorial Hospital, Crystal City, Manitoba.

General Duty Nurses for 404-bed hospital. Starting salary: $245 per mo.; $255 for afternoons & nights. Apply Nursing Service, St. Vincent's Hospital, 2475 N.W. Westover, Portland 10, Oregon.

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General Duty Nurses for 110-bed hospital in scenic Fraser Valley, 65 miles east of Vancouver on Trans-Canada Highway. Salaries, holidays, etc., in accordance with R.N.A.B.C. personnel practices. Residence accommodation available. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

Registered Nurses for Supervision & General Duty in 145-bed hospital for Tuberculosis. Full maintenance available. Salary & personnel policies on application. Apply Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal 5, Que.

Nursing Instructor to teach **Tuberculosis Nursing** to affiliating students in 200-bed sanatorium. Living accommodation in new modern residence. Apply Director of Nursing, Essex County Sanatorium, Windsor, Ontario.

General Duty Nurses for new hospital opening latter part of Aug. 65 miles from Montreal. Excellent bus & train service. Salary: $140 per mo.; full maintenance. 8-hr. duty — rotating shifts. 1½ days off per wk. 30 days annual holiday plus 7 statutory holidays. 12 days sick leave allowance. Blue Cross. Personnel policies on application. Apply Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que.

General Duty Nurses for 175-bed Pediatric Hospital. A.N.P.Q. salary scales & personnel policies in force. Apply Director of Nursing, The Children's Memorial Hospital, Montreal 25, Quebec.

Nurses: Operating Room (1) & Obstetrical (1) — each responsible for small dept. No shift work. Also **General Duty Nurses.** Modern 35-bed General Hospital near Toronto. Salary: $200 & up, less $30 for full maintenance. Rotating shifts. Apply, giving details of training & experience, Supt., Stevenson Memorial Hospital, Alliston, Ont.

Public Health Nurse — Yukon Territory. Applications will be received for the above mentioned appointment with headquarters at Whitehorse, Y.T. Applicants should state age, academic & nursing qualifications, public health qualifications & experience & forward references as to character, ability, training & experience. Appointment effective as from Sept. 1. Salary range: $3,900-4,500 per annum. Usual holiday & sick leave regulations in effect. Apply Dr. Malcolm R. Bow, Chief Medical Health Officer, Yukon Territory, 9544 Riverside Drive, Edmonton, Alta.

Municipal Nurses for Province of Alberta. Rural service, emergency treatment, public health & maternity program. Salary: $2,520-3,300 depending on qualifications & experience plus modern furnished cottage. Excellent sick leave, vacation & pension benefits. Apply Director, Nursing Division, Dept. of Public Health, Administration Bldg., Edmonton, Alberta.

Public Health Nurses for Stormont, Dundas & Glengarry Health Unit for generalized program. Starting salary dependent on experience. Apply Dr. R. S. Peat, Medical Officer of Health, 104-2nd St. W., Cornwall, Ont.

Stop Press!

HELEN G. McARTHUR, immediate past president of the Canadian Nurses' Association, will leave shortly for a year's service in Korea, the Canadian Red Cross Society has announced. Miss McArthur has been selected to represent the League of Red Cross Societies as Associate Co-Ordinator of Relief for Korea. She will replace Mr. Albert Batten, National Director of First Aid for the Canadian Red Cross Society, who has been the League's representative in Korea for the past year.

In addition to coordinating all foreign Red Cross Aid in Korea, Miss McArthur will act as adviser to the Korean Red Cross. This struggling Society, having lost approximately two-thirds of its professional staff and most of its supplies during the war there, has been making a determined effort to rehabilitate itself. It has been receiving substantial support from the Canadian Red Cross Society in the form of an annual grant of $15,000 towards its administrative expenses, an annual grant of $20,000 from the Junior Red Cross to finance a self-help sewing project for the Korean Juniors, as well as shipments of clothing and bedding for its hospital and sanatorium.

Miss McArthur, who for the past eight years has been national director of nursing services for the Canadian Red Cross Society, is eminently qualified for this appointment as, apart from a strong Junior Red Cross, the programs of the Korean Red Cross are mainly of a medical and nursing type. A 200-bed hospital is operated in Seoul and a 100-bed tuberculosis sanatorium for children in Inchen. In addition, ten Chapters operate both permanent and mobile medical clinics, The Society has its own small school of nursing in connection with which Miss McArthur's advice and assistance will be invaluable.

The Korean Society is also depending upon Miss McArthur to help in organizing new Chapters. Her varied experience also includes this type of knowledge as she was responsible for organizing the Newfoundland Division of the Canadian Red Cross Society when Newfoundland became Canada's tenth province.

Public Health Nurses for City of Guelph for generalized program. Car allowance or car provided. Allowance for experience, annual increment, sick benefits. For particulars apply Dr. G. Q. Sutherland, M.O.H., City Hall, Guelph, Ont.

General Duty Nurse for 17-bed hospital, about 100 miles from Calgary. Salary: $170 with full maintenance. Increase of $5.00 per mo. after each 6 mos. service up to 3 increases. Transportation refunded after 6 mos. service. Usual vacation & statutory holidays. Apply Municipal Hospital, Elnora, Alta.

General Duty Nurses for 40-bed hospital on all-weather highway to Vancouver. 42-hr. wk. 28 days annual holiday plus 10 statutory holidays. Rotating shifts, annual increases, cumulative sick leave. Self-contained residence. Monthly salary: $250; full maintenance, $45 per mo. Travelling expenses advanced if necessary. Apply Director of Nursing, General Hospital, Princeton, B.C.

Senior Instructor to teach Nursing Arts & Surgical Nursing & aid with administration of school program. One class per yr. of approx. 20. Salary: $260-290; credit given for experience. 40-hr. wk. 1½ days per mo. sick leave cumulative. 11 statutory holidays. 1 mo. vacation. May live in or out of residence. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses for 108-bed modern hospital. Starting salary: $175 per mo. plus meals & laundry of uniforms. Additional for evening & night duty. Increase at 6 mos. & annually thereafter for further 2 yrs. 44-hr. wk. 8 statutory holidays. 21 days holidays after 1 yr. service. Travelling expenses from point of entry into Ontario refunded after 6 mos. service. Cumulative sick time. Medical & hospital plans available. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

Official Directory

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1411 Crescent St., Montreal 25, Que.

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